STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 000}	INITIAL COMMENTS This visit was for a post-certification revisit (PCR) survey to the PCR survey completed on 7/3/13 to the 23 day revisit survey completed on 6/4/13 to the full annual recertification and state licensure survey which resulted in an Immediate Jeopardy completed on 5/20/13. Dates of Survey: 8/12, 8/13, 8/14, 8/15 and 8/16/13 Facility Number: 000768 Provider Number: 15G245 AIMS number: 100234520 Surveyors: Paula Chika, QIDP-TC Christine Colon, QIDP Amber Bloss, QIDP These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/23/13 by Ruth Shackelford, QIDP.	{W 000}		
{W 102}	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: Based on observation, interview and record review the Condition of Participation: Governing Body was not met for 1 of 2 sampled clients (#2) and for 1 additional client (#3). The governing	{W 102}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

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{W 102}	Continued From page 1	{W 102}		

body failed to ensure client #2 was not neglected in regard to the client's diabetes and to ensure client #3 was not neglected in regard to the client's weight loss. The governing body failed to ensure the facility's nursing services met the health care needs of clients. The governing body failed to ensure the facility initiated investigations of all allegations of neglect when informed, conducted thorough investigations and/or implemented corrective measures to prevent recurrence of neglect in regard to discharged clients.

Findings include:

1. The governing body failed to meet the Condition of Participation: Client Protections for 1 of 2 sampled clients (#2) and for 1 additional client (#3). The governing body failed to implement its written policy and procedures to prevent neglect in regard to the clients' health/medical needs. The governing body failed to conduct a thorough investigation in regard to an allegation of neglect in regard to a nursing medication error, and to ensure corrective actions were followed. Please see W122.

2. The governing body failed to meet the Condition of Participation: Health Care Services for 1 of 2 sampled clients (#2) and for 1 additional client (#3). The governing body failed to ensure the facility's Health Care Services met the health care needs of the clients it served. The governing body failed to ensure the facility's Health Care Services assessed, monitored and/or addressed a client's health care needs in regard to diabetes. The governing body failed to ensure the facility's Health Care Services contacted a client's doctor in regard to the client's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

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{W 102}	Continued From page 2	{W 102}		

elevated/high blood sugar levels, and to obtain clarification in regard to when to contact the physician, to ensure a risk plan was revised and/or developed for client #2. The governing body failed to ensure its facility's Health Care Services monitored and/or assessed client #3's weight loss. Please see W318.

3. The governing body failed to implement its written policy and procedures to prevent neglect of client #2's diabetes. The governing body failed to ensure the interdisciplinary team reviewed and/or addressed the client's elevated blood sugar levels in regard to the client's diet. The governing body failed to ensure the facility specifically indicated how client #2 would be monitored at night in regard to the client's signs/symptoms of low/high blood sugar levels to ensure any change of condition could be immediately addressed. The governing body failed to monitor client #2's low and high blood sugar readings as outlined by the client's physician's order and/or program plan. The governing body failed to ensure the facility's nursing services met the client's health needs in regard to assessing the client timely upon discharge from the hospital and to ensure nursing services carried out physician's orders as written. The governing body failed to ensure the facility notified the client's physician of a hospitalization and/or notified the physician of high blood sugar level readings. The governing body failed to ensure the facility informed/involved the dietician in the interdisciplinary team process to assist the facility to review/address the client's elevated sugar levels in regard to the client's diet, and to develop a risk plan for a medical condition. The governing body failed to implement its written policy and procedures to ensure an investigation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{W 102}	Continued From page 3	{W 102}		

was initiated in regard to an allegation of neglect (medication error) at the time of the incident. The facility's governing body failed to implement its written policy and procedures to prevent neglect of client #3 in regard to the client's weight loss.

The governing body failed to ensure the facility initiated an investigation in regard to an allegation of possible neglect regarding a medication error, when the incident occurred and/or failed to conduct a thorough investigation into the allegation/incident for client #2.

The governing body failed to ensure the facility implemented recommended corrective action to ensure all group home nurses were retrained in regard to hospital discharges.

The governing body failed to ensure its Health Care Services specifically indicated how client #2 would be monitored at night in regard to the client's signs/symptoms of low/high blood sugar levels to ensure any change of condition could be immediately addressed. The governing body failed to ensure its Health Care Services monitored client #2's low and high blood sugar readings as outlined by the client's physician's order and/or program plan, assessed a client timely upon discharge from the hospital and to ensure nursing services carried out physician's orders as written, to ensure the client's physician was notified of a hospitalization and/or notified the physician of high blood sugar level readings, to ensure the dietician was informed/involved in the interdisciplinary team process to assist the facility to review/address the client's elevated sugar levels in regard to the client's diet, and to develop a risk plan for a medical condition. The governing body failed to ensure its Health Care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{W 102}	Continued From page 4 Services re-assessed client #3's weight loss, obtained weekly ordered weights and/or monitored the client in regard to his weight loss. Please see W104. This deficiency was cited on 7/3/13. The facility failed to implement a systemic plan of correction to prevent recurrence.	{W 102}		
{W 104}	9-3-1(a) 483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, interview and record review for 1 of 2 sampled clients (#2) and for 1 additional client (#3), the governing body failed to exercise general policy and operating direction over the facility to ensure client #2 was not neglected in regard to the client's diabetes and to ensure client #3 was not neglected in regard to the client's weight loss. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's nursing services met the health care needs of clients. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility initiated investigations of all allegations of neglect when informed, conducted thorough investigations and/or implemented corrective measures to prevent recurrence of neglect in regard to discharged clients.	{W 104}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

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{W 104}	Continued From page 5 Findings include: 1. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent neglect of client #2's diabetes, to ensure the interdisciplinary team reviewed and/or addressed the client's elevated blood sugar levels in regard to the client's diet, and to specifically indicate how client #2 would be monitored at night in regard to the client's signs/symptoms of low/high blood sugar levels to ensure any change of condition could be immediately addressed. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility monitored client #2's low and high blood sugar readings as outlined by the client's physician's order and/or program plan to ensure the facility's nursing services met the client's health needs in regard to assessing the client timely upon discharge from the hospital, to ensure nursing services carried out physician's orders as written, and to ensure the client's physician was notified of a hospitalization and/or notified the physician of high blood sugar level readings. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's dietician was informed/involved in the interdisciplinary team process to assist the facility to review/address the client's elevated sugar levels in regard to the client's diet, and to develop a risk plan for a medical condition. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policy and procedures to ensure an investigation was initiated in regard to an allegation of neglect (medication error) at the time of the incident. The	{W 104}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

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{W 104}	Continued From page 6	{W 104}		

governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent neglect of client #3 in regard to the client's weight loss. Please see W149.

2. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility initiated an investigation in regard to an allegation of possible neglect regarding a medication error, when the incident occurred and/or failed to conduct a thorough investigation into the allegation/incident for client #2. Please see W154.

3. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented recommended corrective action to ensure all group home nurses were retrained in regard to hospital discharges. Please see W157.

4. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's Health Care Services specifically indicated how client #2 would be monitored at night in regard to the client's signs/symptoms of low/high blood sugar levels to ensure any change of condition could be immediately addressed, and to ensure the facility's Health Care Services monitored client #2's low and high blood sugar readings as outlined by the client's physician's order and/or program plan. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's Health Care Services met the client's health needs in regard to assessing the client timely upon discharge

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{W 104}	Continued From page 7 from the hospital and to ensure nursing services carried out physician's orders as written, to ensure the client's physician was notified of a hospitalization and/or notified the physician of high blood sugar level readings, and to ensure the dietician was informed/involved in the interdisciplinary team process to assist the facility to review/address the client's elevated sugar levels in regard to the client's diet. The governing body failed to exercise general policy and operating direction over the facility to ensure its health care services developed a risk plan for a medical condition, re-assessed client #3's weight loss, obtained weekly ordered weights and/or monitored client #3 in regard to the client's weight loss. Please see W331. This deficiency was cited on 7/3/13. The facility failed to implement a systemic plan of correction to prevent recurrence.	{W 104}		
{W 122}	9-3-1(a) 483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 1 of 2 sampled clients (#2) and for 1 additional client (#3). The facility failed to implement its written policy and procedures to prevent neglect in regard to the clients' health/medical needs. The facility failed to conduct a thorough investigation	{W 122}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 122}	Continued From page 8	{W 122}		

in regard to an allegation of neglect in regard to a nursing medication error, and to ensure corrective actions were followed.

Findings include:

1. The facility failed to implement its written policy and procedures to prevent neglect of client #2's diabetes. The facility failed to ensure the interdisciplinary team reviewed and/or addressed the client's elevated blood sugar levels in regard to the client's diet. The facility failed to specifically indicate how client #2 would be monitored at night in regard to the client's signs/symptoms of low/high blood sugar levels to ensure any change of condition could be immediately addressed. The facility failed to monitor client #2's low and high blood sugar readings as outlined by the client's physician's order and/or program plan. The facility failed to ensure the facility's nursing services met the client's health needs in regard to assessing the client timely upon discharge from the hospital and to ensure nursing services carried out physician's orders as written. The facility failed to ensure the client's physician was notified of a hospitalization and/or notified the physician of high blood sugar level readings. The facility failed to ensure the dietician was informed/involved in the interdisciplinary team process to assist the facility to review/address the client's elevated sugar levels in regard to the client's diet, and to develop a risk plan for a medical condition. The facility failed to implement its written policy and procedures to ensure an investigation was initiated in regard to an allegation of neglect (medication error) at the time of the incident. The facility failed to implement its written policy and procedures to prevent neglect of client #3 in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 122}	Continued From page 9 regard to the client's weight loss. Please see W149. 2. The facility failed to initiate an investigation in regard to an allegation of possible neglect regarding a medication error, when the incident occurred and/or failed to conduct a thorough investigation into the allegation/incident for client #2. Please see W154. 3. The facility failed to implement recommended corrective action to ensure all group home nurses were retrained in regard to hospital discharges for client #2. Please see W157. This deficiency was cited on 7/3/13. The facility failed to implement a systemic plan of correction to prevent recurrence.	{W 122}		
{W 149}	9-3-2(a) 483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on observation, interview and record review for 1 of 2 sampled clients (#2) and for 1 additional client (#3), the facility neglected to implement its written policy and procedures to prevent neglect of client #2's diabetes. The facility neglected to ensure the interdisciplinary team reviewed and/or addressed the client's elevated blood sugar levels in regard to the client's diet. The facility neglected to specifically indicate how client #2 would be monitored at night	{W 149}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 149}	Continued From page 10	{W 149}		

in regard to the client's signs/symptoms of low/high blood sugar levels to ensure any change of condition could be immediately addressed. The facility neglected to monitor client #2's low and high blood sugar readings as outlined by the client's physician's order and/or program plan. The facility neglected to ensure the facility's nursing services met the client's health needs in regard to assessing the client timely upon discharge from the hospital and to ensure nursing services carried out physician's orders as written. The facility neglected to ensure the client's physician was notified of a hospitalization and/or notified the physician of high blood sugar level readings. The facility neglected to ensure the dietician was informed/involved in the interdisciplinary team process to assist the facility to review/address the client's elevated sugar levels in regard to the client's diet, and to develop a risk plan for a medical condition. The facility neglected to implement its written policy and procedures to ensure an investigation was initiated in regard to an allegation of neglect (medication error) at the time of the incident. The facility neglected to implement its written policy and procedures to prevent neglect of client #3 in regard to the client's weight loss.

Findings include:

1. The facility's reportable incident reports, Incident/Accident Reports (IAR) and/or investigations were reviewed on 8/12/13 at 3:23 PM. The facility's reportable incident reports, IARs and/or investigations indicated the following:

-7/10/13 "This Service Coordinator (SC) (SC #1) received a phone call from the group home at approximately 8:30 AM on 7/10/13 stated that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

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{W 149}	Continued From page 11	{W 149}		

consumer [client #2] appeared lethargic and his gait was unsteady (sic). Staff were directed to check his blood glucose level. It was 210. The nurse directed staff to transport [client #2] to [name of hospital] in [name of city], In. Blood tests and CT scan yielded no significant findings. [Client #2] was not admitted to the hospital, he was discharged from the ER (emergency room) at 12:30 PM on 7/10/13. No new medications, prescriptions for a walker provided by the ER physician.

At 1:00 PM Residential staff transported consumer [client #2] from the hospital to the group home after ER discharge. Upon disembarking the vehicle (at group home) [client #2's] body shook uncontrollably. Staff assisted [client #2] to the ground, no injury noted. 911 called...[Client #2] was transported back to the ER via ambulance.

At 2:00 PM, the ER physician noted low Depakote (seizure) levels from previous work (taken at initial visit). Consumer [client #2] was given Zalerate 100ml (milliliters) intravenously while in the ER to bring his depakote levels up. [Client #2] was discharged from the ER at 5:00 PM on 7/10/13. No new medications, prescription for a walker written. The ER physician recommended that [client #2] follow-up with his primary care physician (PCP) and that [client #2] continue to take his current medications as prescribed."

The facility's 7/19/13 follow-up report indicated client #2 saw his PCP. The follow-up report indicated client #2's "...increasing unsteadiness and uncoordinated movements are correlated with his diagnosis of Parkinson's Disease (disorder of the brain that lead leads to tremors

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 149}	Continued From page 12	{W 149}		

and difficulty walking). It is recommended he follow-up with a neurologist...." The follow-up report also indicated client #2 would see a physical therapist (PT) and occupational therapist (OT) for the need/use of adaptive equipment.

-7/11/13 "[Client #2] came into the workshop at 9:00 AM with signs of hyperglycemia (high blood sugar) which included shakiness and combativeness. Health & (and) Safety (H&S) tech tested [client #2's] sugar level which was 369. [Client #2] was given water and H&S Tech contacted Residential Nurse and left message with Director of Health Services. [Client #2] was closely monitored by staff and H&S Tech for any changes. [Client #2's] level was checked again and tested at 463. Facility Director called 911 and EMT (emergency medical technician) arrived and checked [client #2's] levels which tested at 476. [Client #2] was then transported to [name of hospital]."

The facility's 7/17/13 follow-up report indicated client #2 followed up with his Endocrinologist (diabetes specialist) on 7/15/13 and the doctor changed the client's insulin dosage.

-7/26/13 "Consumer [client #2] was non-responsive during a routine bed check. Staff checked [client #2's] glucose and it was in the 40's, and the Nurse was notified. 911 was called and [client #2] was transported to [name of hospital]."

-7/31/13 "[Client #2] was at [name of hospital] in [name of city], Indiana for a scheduled EEG on 7/31/13. During the procedure [client #2] began to show signs of hypoglycemia (low blood sugar). His sugar dropped below 30. [Client #2] was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 149}	Continued From page 13	{W 149}		

rushed to [name of hospital] emergency room. His blood sugar was stabilized and he was admitted to the hospital for further observation."

The facility's 7/31/13 IAR indicated client #2 would not respond to staff when they called his name. The IAR indicated the client was taken to the ER where it was determined his blood sugar level was below 30 and he was admitted to the hospital.

-8/5/13 "Director of Health Services (DHS) reviewed hospital discharge orders for [client #2], which instructed that his blood sugar levels were to be checked prior to lunch to determine if insulin coverage was needed. The nurse failed to follow up and train day program staff on the new doctor orders. Which resulted in [client #2] not having his blood sugar checked appropriately on 8/5/13 and 8/6/13 (sic). The nurse immediately went to the East center (facility owned day program) to provide Novolog insulin, ensured that the glucometer and test strips were available, transcribed the orders on the MAR (medication administration record), and trained the health and safety tech on the new orders. The Director of Health Services will follow up with [client #2's] primary care physician."

The facility's 8/9/13 follow-up report indicated "...3. What measures are being implemented to prevent this from happening again? Training was done with the nurses which consisted of thorough review of all discharge hospital orders and ensure all orders are carried out."

The facility's 8/5/13 IAR indicated LPN #1 was the nurse involved in the error.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 149}	Continued From page 14	{W 149}		

The facility's 8/8/13 Investigation Fact Sheet Summary and Conclusion indicated the DHS conducted an investigation in regard to possible neglect. The facility's investigation indicated "[Client #2] was discharged home on Friday 8-2-13. Discharge hospital orders were not carried out; nurse did not visit client for post-hospital D/C (discharge) assessment within 24 (hours) as per policy. Nurse failed to follow-up and train day program staff on the new orders from M.D. (medical doctor)." The facility's 8/8/13 investigation indicated "The allegation is true." The facility's investigation indicated LPN #1 was a nurse from a temporary nurse staffing agency, and the facility did not report the allegation to the staffing agency until 8/13/13. The facility's witness statements indicated LPN #1 was interviewed on 8/13/13, administrative staff #3 on 8/15/13 and Service Coordinator #1 was interviewed on 8/14/13.

Administrative staff #3's 8/15/13 witness statement indicated they were notified of a medication error by the DHS on 8/6/13. The witness statement indicated "The Nursing Director explained that the Service Coordinator gave permission to the hospital to discharge consumer and did not inform the Residential Nurse about the consumer. She stated that the consumer did not receive his insulin or glucose tests for the group home and day service facility. She stated she was going to look further and get back to me with an update. I told her that based on what she told me so far it looked like a med error, and process error...An investigation was not initiated right away because I (administrative staff #3) did not have knowledge of possible neglect of the temp nurse knowing about the discharge of this consumer. Otherwise an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 149}	Continued From page 15	{W 149}		

internal investigation would have been initiated earlier,...."

Service Coordinator (SC) #1's 8/14/13 witness statement indicated on 8/2/13 at 3:30 PM, SC #1 received a phone call indicating client #2 would be discharged from the hospital. The witness statement indicated SC #1 requested the discharge information and physician orders from the hospital and provided them the fax number to the facility. The witness statement indicated SC #1 then told LPN #1 of the discharge. The witness statement indicated the information arrived by fax at 4:15 PM and she gave the information to the nurse for review. The witness statement indicated "...She stated that it was okay and I (SC #1) contacted the Hospital Social Worker and scheduled transportation w/ (with) [name of ambulance company]."

LPN #1's 8/13/13 witness statement indicated she was not told of client #2's discharge from the hospital on 8/2/13. The witness statement indicated "...staff reported it was rumors client would be returning Fri (Friday). On Monday morning this nurse was informed client was home from the hospital. This nurse then follow-up (sic) with paperwork and clarified MD orders, orders were sent to the group home, workshop, area manager, service coordinators via email. The client was not seen within 24 hours from hosp (hospital) discharge and although orders were sent to workshop (sic) staff did not follow through with orders. According to DON (Director of Nursing) I was to be disciplined due to neglect of client according to policy and procedure, I never received the proper training, I never received a policy and procedure handbook. I no longer feel comfortable working for a company that has no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 149}	Continued From page 16	{W 149}		

structure and puts my nursing license in jeopardy." The facility's 8/8/13 investigation neglected to interview day program staff and group home staff in regard to the error/incident, and/or failed to initiate an investigation for possible neglect on 8/5/13 once the error/incident was identified.

The facility's training records were reviewed on 8/12/13 at 4:00 PM. The facility's 8/5/13 Individual Client Training Forms indicated the DHS completed training procedures for discharge, reviewing discharge orders, clarifying orders and following up with treatment and medication changes with LPN #1 and LPN #2 of the group homes.

Interview with administrative staff #2 on 8/12/13 at 4:15 PM indicated the DHS retrained 2 of 4 group home nurses. Administrative staff #2 indicated the DHS only trained the nurses who worked with the Fourteenth Lane group home. Administrative staff #2 stated LPN #1 and LPN #2 were not the only nurses who worked on call as LPN #1 was a "temporary" (part time) nurse and LPN #2 was a full time nurse. The facility neglected to train all nurses in regard to discharge orders to ensure continuity of care with clients.

During the 8/12/13 observation period between 5:15 PM and 7:10 PM, at the group home, client #2 did not wear a gait belt and/or utilize a walker. Staff #1 and #2 did not implement any desensitization training with client #2.

Client #2's record was reviewed on 8/12/13 at 5:22 PM and on 8/13/13 at 1:10 PM. Client #2's 7/10/13 hospital records indicated client #2 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 149}	Continued From page 17	{W 149}		

seen in the ER on 7/10/13. The 7/10/13 ER note indicated client #2's diagnoses included, but were not limited to, "Uncoordinated movements, Parkinson Disease, and Type II diabetes mellitus without control." The ER note indicated client #2 was to follow-up with his PCP in 2 days and a "roller walker" was ordered for client #2. Client #2's 7/10/13 lab report indicated client #2's glucose level was 280 at the ER and the client's Valproic Acid level was "22.5 (L)." Client #2's second 7/10/13 ER note indicated client #2's diagnosis included, but was not limited to, Convulsions." The second 7/10/13 note indicated client #2's seizures were "Non-Epileptic Seizures." The attached 7/10/13 Discharge Instructions indicated "Non-epileptic seizure (NES) is a short period of symptoms that change how you move, think, or feel. NES looks like an epileptic seizure, but there are no electrical changes in the brain. NES is a serious condition. Early diagnosis and treatment are needed to prevent further problems...."

Client #2's 7/31/13 History and Physical (H&P) indicated client #2 was seen in the ER for the chief complaint of Hypoglycemia. The H&P indicated "...patient was reportedly developing diaphoresis (excessive sweating commonly associated with shock and other medical emergency conditions) and restless while having EEG done today; patient was noted to have low blood sugar. Hypoglycemia has been recurrent past few days; had 3 ER visits at local ER...." The 7/31/13 H&P indicated client #2 had "renal insufficiency, most likely from medication effect....Will consult [name of doctor] nephrology...."

An 8/2/13 After Visit Summary indicated client #2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 149}	Continued From page 18	{W 149}		

was discharged back to the group home on 8/2/13. The summary indicated client #2 was to follow up with his PCP in 1 week and the nephrologist in 5 weeks with labs to be done in 4 weeks. The 8/2/13 summary indicated client #2 was placed on a sliding scale. The 8/2/13 summary indicated "Other Prescriptions... Novolog Mix 70/30 Flex pen inject 5 units into the skin 2 (two) times daily before meals" and "insulin apart (sliding scale insulin coverage) Novolog Flex Pen inject three times daily with meals BS (blood sugar) 150-199 1U (unit) SQ (subcutaneous)
200-249-2U SQ
250-300-3U SQ
301-349-4U SQ
350-400-5U SQ
> (more than) 400-6 units SQ call MD (medical doctor)." The 8/2/13 Patient Instructions indicated the facility was to monitor client #2's glucose levels 4 times daily at meals and at bedtime (HS). The 8/2/13 After Visit Summary indicated a doctor at the hospital made the medication changes, not client #2's PCP and/or endocrinologist.

Client #2's 8/6/13 Nephrology report indicated client #2's diagnosis included, but was not to limited to, "Chronic kidney disease, stage 3" (moderately reduced kidney function).

Client #2's Cumulative Medical Records and physician orders indicated the following (not all inclusive):

-7/10/13 "Sent to E.R. for eval (evaluation) & tx (treatment) d/t (due to) staff reporting (change) in medical condition (unsteady gait)."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 149}	Continued From page 19	{W 149}		

-7/10/13 "Eval @ (at) [name of hospital] DX: uncoordinated movements, Parkinson Disease, Type II DM (diabetes mellitus), convulsions. Labs & CT head done. Rx (prescription) for walker. Appt (appointment) (with) [name of doctor] (neurologist) 7-23-13 @ 10 AM, Appt OT/PT eval - 7-19-13 @ 9 AM."

-7/11/13 "Gait belt DX (diagnosis): unsteady gait."

-7/15/13 (8:25 AM) "Blood Sugar (increase) 419. Status update given to [name of endocrinologist] office- Client taken to Dr's (doctor's) office- orders rec'd (received) to (increase)- a.m. insulin dose to 20 units and p.m. dose to 10 units and return to office in 4 weeks- appt scheduled 8-15-13 @ 10:30 AM."

-7/22/13 "Rec'd phone call from staff on 7-20-13 @ 7:15 pm- reports client BS 21 glucagen subcut (subcutaneous) given - unable to wake client up- breathing/snoring loud; sweating profusely- informed to call 911 immediately. EMS admin. IV Dextrose as per staff BS (increased) to 100 - client aroused- no ER transport needed - informed to give dinner, hold P.M. insulin dose @ this time; monitor condition; repeat BS @ 10 PM & call on-call nurse (with) results. At 10 PM- blood sugar 265- Continue to monitor client throughout night."

-7/23/13 "...New Neuro pt (patient) sent here at the request of the DON (Director of Nursing) at The Arc. Pt has been diagnosed with Parkinson Disease. Pt was recently seen in the ER at [name of hospital] for full body tremors per the social worker here with him today. Pt is on Depakote but he doesn't have a diagnoses (sic) of seizures." The 7/23/13 note indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 149}	Continued From page 20	{W 149}		

Carbidopa-Levodopa (Parkinson Disease) 25-100 milligrams daily with meals. The note indicated the facility was to start with breakfast for 1 week, then 1 with breakfast and lunch for 1 week, then 1 with each meal. The neurology report indicated the Neurologist ordered an EEG awake and asleep for client #2. The report also indicated client #2 was to return in 6 weeks or as needed. The 7/23/13 report indicated client #2 was given a diagnosis of Seizure.

-7/23/13 "Spoke w/ (with) [name of endocrinologist] re: (referring to) elevated blood sugars over 300 and no return phone calls when Dr. paged; orders rec'd to continue to call [name of endocrinologist] for BS > 300 via pager or cell phone; insulin increased to 25 units @ bkfst (breakfast) and 20 units (with) dinner & F/U (follow-up) for appt next wk (week) (call for appt)."

-7/23/13 Faxed note indicated "1.) Continue to call [name of endocrinologist] for blood sugars > 300. His cell number is [number listed] or pager [number listed]. 2. Increased Novelin 70/30 to 25 units before breakfast & 20 units before dinner. Please make sure patient eats when you give insulin." On the bottom of the attached order sheet, the facility's nurse sought clarification in regard to the medication as it was to be Novolog 25 before breakfast and 20 units at supper.

-7/23/13 (5:30 PM) "While visiting home (this writer) (Director of Health Services)- client's BS 45 informed to hold p.m. insulin- 1 cup milk, slice of bread & serving of rice given prior to leaving home for outing. Staff informed to obtain BS during outing (with) any s/s (signs and symptoms) of hypo/hyperglycemia & repeat BS when return to home."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 149}	Continued From page 21	{W 149}		

-7/23/13 (8:20 PM) "Client (without) incident @ outing. B.S. 53 when returned home- sub Q (subcutaneous) glucagen given per staff; ate supper @ outing around 7-7:15 pm- informed to repeat BS in 1 hour- call w/results. 9:25 PM BS up to 98 informed to give HS snack graham crackers & cup of milk."

-undated note "In case of emergency go to the emergency room of the hospital closest to you and have [name of endocrinologist] paged [pager number listed] wait for two beeps then place in your number with a touch tone phone. Then wait two beeps again. Then hang up. [Name of endocrinologist] will return your call. [Name of Endocrinologist] wants to also be notified about B/S over 300...Low BS- Milk or juice."

-7/26/13 "Rec'd phone call from staff @ 5:40 a.m. S 47- client sweating profusely; c/o (complaints of) stiff muscles - informed to call 911- adm (administer) sub Q glucagen. This writer (DHS) arrived @ home approx (approximately) 6:15 a.m. - EMS present - BS 42 per EMS; IV dextrose given- [client #2] cont. (continue) to sweat profusely/EMS attempting to arouse - repeat BS per EMS after IV dextrose (decreased) 30's - taken to E.R. for evaluation."

-7/26/13 Novolog 70/30 ordered 15 units with breakfast and 10 units with dinner.

-7/31/13 Client #2 went to hospital for EEG testing and showed signs of hypoglycemia. The note indicated client #2 was transported to the ER and admitted with a blood sugar below 30. The note indicated client #2 was to have a kidney ultrasound and blood work completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 149}	Continued From page 22	{W 149}		

-8/5/13 "Assessed client post hosp (hospital) return. Client alert et (and) non verbally responsive. 0 (zero) signs of distress noted resp (respirations) even & unlabored bilat (bilateral) lung sounds clear, bowels active x 4 quads, skin W/D intact. V/S (vital signs) stable, new orders received et noted. Client to follow up (with) [name of PCP] in 1 wk et [name of Neurologist] in 5 wks." The facility neglected to assess client #2 upon discharge from the hospital on 8/2/13 and/or ensure the new orders were implemented.

-8/12/13 Client #2 saw his family doctor for a follow-up to the 7/31/13 hospitalization.

Client #2's 7/19/13 PT and OT evaluation indicated client #2 was a fall risk and should exercise safety around sharp objects or moving objects. The assessment indicated client #2 was "...unable to follow 1 step commands consistantly (sic)...." The PT assessment indicated "Current Home Program: pt is unable to follow any exercises. No HEP (home exercise program) provided/Pt inappropriate...Recommendation/Plan OT Plan **Requires OT follow Up**: No PT is not appropriate for OT services at this time. Recommend 24 hour supervision in structured environment. This patient will be seen for skilled occupational therapy for optimal return to independence with meaningful occupations...."

Client #2's 8/5/13 Medication Change Form indicated client #2 had a new medication order/change. The 8/5/13 form indicated "Give Novolog 70/30 5 units 2xs (times) a day before breakfast and dinner subq. Give Insulin apart Novolog 3xs a day with meals subq if BS reading

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 149}	Continued From page 23	{W 149}		

is
150-199 give 1unit
200-249 give 2units
250-300 give 3units
301-349 give 4 units
350-400 give 5 units
If BS is greater than 400 give 6units (sic) and call Nurse/MD...."

The 8/5/13 change form and/or Cumulative Medical Record indicated the facility neglected to obtain clarification in regard to when the doctor and/or endocrinologist wanted to be notified as the 7/23/13 order indicated at 300 and the 8/5/13 order indicated 400.

Client #2's August 2013 Medication Administration Record (MARs) indicated the facility monitored client #2's blood sugar levels in the morning, lunch, PM (evening before dinner) and at bed time. Client #2's 8/13 MAR indicated the following blood sugar levels (not all inclusive):

-8/2/13 bed time 328
-8/3/13 lunch 444
-8/3/13 bed time 312
-8/4/13 lunch 352
-8/4/13 bed time 341
-8/5/13 morning 304
-8/5/13 evening/dinner 342
-8/6/13 evening/dinner 310
-8/8/13 evening/dinner 321
-8/10/13 lunch 334
-8/10/13 evening/dinner 435
-8/10/13 bed time 371
-8/11/13 lunch 344
-8/11/13 evening/dinner 439
-8/11/13 bed time 352.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 149}	Continued From page 24	{W 149}		

The facility's Residential Services Pager Review was reviewed on 8/13/13 at 1:40 PM. The facility's pager records indicated the following in regards to client #2's blood sugar levels/readings:

-7/8/13 302 at 5:55 PM, client #2 was "unsteady and shaking."
-7/18/13 352 at 8:07 AM
-7/18/13 353 at 6:12 PM, and then 379 with a different glucometer.
-7/22/13 408 at 5:53 PM
-7/24/13 330 at 9:18 PM
-7/27/13 487 at 6:30 PM "Give p.m. insulin dose feed dinner. Call back w/results in 2-21/2 hours after eating. 10 pm BS going down 337."
-7/28/13 398 at 6:20 PM "Informed to give p.m. insulin dinner re(check) in 2/1/2-3 hrs (hours). Call w/results."
-8/2/13 328 at 10:31 PM
-8/3/13 456 at 10:41 AM
-8/3/13 444 at 1:39 PM
-8/4/13 341 (no time documented)
-8/5/13 304 at 6:50 AM.

Client #2's pager log and/or Cumulative Medical Record indicated the facility neglected to call/inform the doctor/endocrinologist of client #2's high blood sugar readings over 300 prior to 8/5/13 and/or over 400 after 8/5/13.

Client #2's undated typed sheet indicated client #2 was to carry a sack lunch and a snack to the day program daily, document what was sent and what the client ate.

Client #2's 8/2013 food journal book indicated client #2 received an 1800 calorie ADA (diabetic) diet. Client #2's 8/2013 menus indicated "Hot lunch Eat at workshop" on 8/8/13, 8/9/13,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 149}	Continued From page 25 8/12/13, 8/15/13, 8/16/13, 8/19/13, 8/22/13, 8/23/13, 8/26/13, 8/29/13 and 8/30/13. Client #2's 8/2013 food journal book indicated the following menu/food items sent for the client's lunch on the following days: -8/8/13 Three ounces of chicken, 1/2 cup macaroni and cheese, 1/2 cup potatoes, 1 slice of bread, orange slices and water. -8/9/13 Three ounces of meat, 1/2 cup of noodles, garlic bread, 1/2 cup of peas and carrots, 1 cup mandarin oranges, water and 8 ounce cup of milk. -8/11/13 Three ounces of polish sausage, 1/2 cup dirty rice, 1/2 bun, salad, fruit cup, yogurt and water. -8/12/13 2 sliced hot dogs, 1 slice of bread, 1 serving of rice, 1 serving of salad, fruit cup, graham crackers and 16 ounces of water. Client #2's 1800 calorie ADA diet indicated the facility neglected to have the dietician review, develop and/or approve the above mentioned sack lunch menus for client #2. Client #2's 8/13 menu indicated the facility neglected to develop an approved sack lunch menu for the upcoming days of 8/15/13, 8/16/13, 8/19/13, 8/22/13, 8/23/13, 8/26/13, 8/29/13 and 8/30/13. Client #2's 6/5/13 Annual Nutritional Assessment indicated "...Client on Diabetic 1800 calorie meal plan as ordered by MD. Staff monitor carbohydrate counting at mealtime. Continue to monitor blood sugar." The facility neglected to ensure the dietician reviewed and approved all	{W 149}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 149}	Continued From page 26	{W 149}		

lunch menus developed by the group home staff. The facility neglected to have client #2's 1800 calorie ADA diet re-assessed in regard to the client's high/low blood sugar levels to ensure the menus did not contain a lot of starches, carbohydrates and/or natural sugars which could affect client #2's blood sugar levels.

Client #2's 8/7/13 Diabetic (risk) Plan indicated "Menus are developed and sent to the Nutritionist for review for approval and revisions." The 8/7/13 risk plan indicated client #2 was to carry a sack lunch daily. The 8/7/13 risk plan indicated "...During sleep check for crying out or thrashing in bed as he may be having nightmares. He may sweat through his clothing. If noted check his blood sugar. If blood sugar is above 400 check for the following symptoms (Hyperglycemia)
-Frequent urination
-Fatigue
-Abdominal Pain
-Dry Mouth
-Increased thirst
-Headache
-Nausea and Vomiting
-Weakness
-blurred (sic) vision
-Fruity smelling breath
-Shortness of Breath
-Confusion
If blood sugar is above 150 Novolog flexpen 100units/ml injection will be administered per sliding scale MD orders, (sic) If [client #2's] blood sugar is above 400 6units (sic) of Novolog flexpen should be administered Sub-Q per sliding scale MD orders and Call the nurse/nurse to notify MD...If 911 is called an Incident report should be completed....." Client #2's 8/7/13 risk plan neglected to specifically indicate how often

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 149}	Continued From page 27	{W 149}		

facility staff were to monitor client #2 at night in regard to the client's signs/symptoms of low/high blood sugar levels to ensure any change of condition could be immediately addressed.

Client #2's 7/2013 risk plan for Parkinson's Syndrome indicated "Staff will to monitor [client #2] while ambulating (sic)...Staff will make sure that [client #2] and the bathroom floor are fully dried after showering/bathing...Staff will make sure walkways are clear of obstacles and tripping hazards...[Client #2] has been prescribed a gait belt and walker. However, at this time he is combative in using the gate (sic) belt and the walker. A desensitization plan has been developed please see this plan...." Client #2's 7/2013 risk plan indicated the facility neglected to specifically indicate when staff should attempt to use the gait belt, and/or indicate how the facility staff were to keep the client safe when the client's gait was unsteady. Client #2's record and/or 2/28/13 Individual Program Plan (IPP) indicated the facility neglected to address/develop a risk plan for the client's Chronic Kidney Disease.

Client #2's 7/13 behavior plan indicated "A gait belt and walker has (sic) been recommended for [client #2] to reduce these falls. He is extremely resistant to these items. A desensitization plan for this is being added to his plan. [Client #2] is also resistant to some medical appointment desensitization for appointment is also be in added (sic). Client #2's 7/13 behavior plan indicated the desensitization plans for the gait belt and the walker were to be run/implemented 5 times a day at the group home and at the day program.

Client #2's 2/28/13 IPP indicated client #2's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 149}	Continued From page 28	{W 149}		

interdisciplinary team (IDT) met on 7/10/13, 7/11/13 and on 7/19/13. Client #2's above mentioned IDT notes and/or the client's 2/28/13 IPP indicated the IDT neglected to meet since client #2 was discharged from the hospital on 8/2/13 to review and/or make needed changes to the client's risk plans. Client #2's 2/28/13 IPP and/or record indicated the facility neglected to ensure the dietician and/or input was included in the IDT meetings. Client #2's IPP and/or record indicated the facility neglected to review client #2's 1800 calorie ADA diet menus/food journals in regard to the client's high/low blood sugar readings/levels to determine if there was any correlation.

Interview with staff #1, #2 and SC #1 on 8/12/13 at 6:41 PM when asked when client #2 would be transported to the hospital, staff #1 and SC #1 stated client #2 would be transported to the hospital when the client was "unresponsive." SC #1 stated client #2's doctor would be called if it was "significant-irregularities." When asked how client #2 was monitored at night in regard to his blood sugar/symptoms, staff #1 stated "I check him every hour when I work." Staff #2 indicated she did not work midnights.

Interview with the dietician on 8/13/13 at 1:44 PM, by phone, indicated she last assessed client #2 in the month of May 2013. When asked if the facility had contacted her in regard to the client's elevated and low blood sugar levels and his diet, the dietician stated "No." The dietician indicated she was not aware client #2 had been hospitalized until she came to the facility to do an inservice training. When asked if she was aware client #2 was diagnosed with Chronic Kidney Disease stage 3, the dietician stated "No." The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 149}	Continued From page 29	{W 149}		

dietician indicated she was not aware of any insulin changes from the 7/31/13 hospitalization. The dietician stated she would "Definitely want to be notified in regard to low blood sugar or change in medication, diet changes to go back and re-evaluate client." The dietician stated she should be made aware of any "abnormal readings" which were high or low. The dietician stated she did not attend the IDT meetings but had discussed the client's "Plan of Care" in the past. The dietician indicated she had not communicated with the Endocrinologist in regard to the client's menus. The dietician indicated she reviewed and approved the client's menus that were sent to her. The dietician indicated the facility had not asked her to re-assess client #2.

Interview with administrative staff #2, SC #1 and #2, and the DHS on 8/14/13 at 1:50 PM indicated client #2 was hospitalized on 7/31/13 for low blood sugar level reading when the client was at the hospital for an EEG. The DHS indicated client #2 was discharged on 8/2/13 and placed on a sliding scale. The DHS could not locate the order for the changes of the insulin and/or doctor notification. The DHS stated client #2's blood sugar levels were "up and down." The DHS indicated the dietician was aware of client #2's low and high blood sugar level readings. The DHS indicated client #2 started carrying sack lunches July 28, 2013 versus purchasing hot meals at the workshops. The DHS and SC #1 indicated they had not reviewed the menus to ensure all lunches had been reviewed and/or approved by the dietician. SC #1 indicated the 8/2013 menu was approved by the dietician when client #2 was still eating at the workshop. SC #1 indicated no one had resubmitted menus for the days the menu called for eating at the workshop.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 149}	Continued From page 30	{W 149}		

The DHS and DS #1 indicated no one reviewed the menus since the dietician approved them. The DHS, SC #1 and administrative staff #2 indicated the dietician had not attended any IDT meetings. SC #1 stated "No one thought of inviting the dietician to the program (meetings)." SC #1 and #2 indicated there had been no additional IDTs since 7/19/13. The DHS indicated she was not aware client #2 had a diagnosis of Chronic Kidney Disease stage 3. The DHS indicated diabetes could affect the kidneys function. SC #1 and the DHS indicated client #2 did not have a risk plan for his new diagnosis. SC #1 and #2 indicated client #2 did not want to wear his gait belt and/or use a walker. SC #2 indicated client #2 had a desensitization plan for using his walker and gait belt. SC #2 indicated he had trained theday program staff in regard to the desensitization plan, but he had not trained the group home staff in regard to the behavior plan. The DHS indicated client #2 had a diagnosis of Parkinson Disease. The DHS indicated the neurologist and evaluation by the OT and PT indicated client #2 would not be a good candidate for a walker but a gait belt had been put into place. When asked how the facility was keeping client #2 safe as the client did not want to utilize a gait belt, SC #1, the DHS and administrative staff #2 indicated the IDT would need to put something in place. The DHS indicated client #2's Endocrinologist was made aware of client #2's low and high blood sugars. The DHS indicated the doctor would not always return his pages/calls. The DHS indicated she spoke with the doctor on 7/23/13 and nursing staff was to call his office, the pager and/or his cell phone. The DHS indicated the doctor still wanted to be notified if client #2's blood sugar levels were over 300. The DHS indicated she was not aware the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 149}	Continued From page 31	{W 149}		

8/2/13 discharge orders had changed the notification to 400. The DHS indicated the facility's nurse should have sought clarification of the order to notify the doctor of client #2's blood sugar levels over 300 or 400. When asked if the facility's nurse notified the doctor of client #2's following high blood sugar levels, the DHS stated "no (to each one)" as there was no documentation the doctor was called:
-7/8/13 302 at 5:55 PM
-7/18/13 352 at 8:07 AM
-7/18/13 353 at 6:12 PM, and then 379 with a different glucometer.
-7/22/13 408 at 5:53 PM
-7/24/13 330 at 9:18 PM
-7/27/13 487 at 6:30 PM
-7/28/13 398 at 6:20 PM
-8/2/13 bed time 328
-8/3/13 lunch 444
-8/3/13 bed time 312
-8/4/13 lunch 352
-8/4/13 bed time 341
-8/5/13 morning 304
-8/5/13 evening/dinner 342
-8/6/13 evening/dinner 310
-8/8/13 evening/dinner 321
-8/10/13 lunch 334
-8/10/13 evening/dinner 435
-8/10/13 bed time 371
-8/11/13 lunch 344
-8/11/13 evening/dinner 439
-8/11/13 bed time 352.
The DHS indicated the doctor should have been called in regard to blood sugar levels over 300.
The DHS, SC #1 and SC #2 indicated client #2's IPP did not specifically indicate how facility staff were to monitor the client at night in regard to signs and symptoms of high and/or low blood sugars. The DHS and SC #1 indicated the IDT

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 149}	Continued From page 32	{W 149}		

had not re-assessed client #2's diet/food journal/consumption in regard to the client's low and/or high blood sugar levels.

Interview with the Endocrinologist on 8/15/13 at 1:45 PM, by phone, indicated client #2 was a patient he followed. The Endocrinologist indicated he saw client #2 at his office on 8/15/13. The doctor indicated client #2's blood sugar level over 400 in his office. The Endocrinologist indicated when he asked the nurse what client #2's morning blood sugar reading was, the Endocrinologist indicated the nurse could not tell him. The Endocrinologist stated he had written orders for client #2's blood sugar levels to be monitored, but the facility did not bring all the readings with them except the "PM readings." The doctor indicated he made some changes in regard to the client's insulin on 8/15/13. The Endocrinologist indicated the nurse told him the client's PCP was also seeing the client for his diabetes. The doctor stated he told them the PCP could follow his diabetes and if his PCP "could not handle" they could bring the client back to him. When asked if he was aware of client #2's hospitalization, the Endocrinologist asked when client #2 was hospitalized and why. The Endocrinologist indicated he was not aware client #2 had been hospitalized. The Endocrinologist stated "I requested to be notified of hospitalizations. I requested to be notified of blood sugar levels." The Endocrinologist indicated he wanted to be called when client #2's blood sugar levels were over 300. When told it had been changed to 400, the Endocrinologist indicated they should call him when the levels were over 300. The Endocrinologist indicated he had written orders to indicate such. The Endocrinologist indicated he was not aware of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 149}	Continued From page 33	{W 149}		

any food journals. The Endocrinologist stated "They have not shown me any food journals." The Endocrinologist indicated he was concerned the facility was not monitoring client #2's blood sugar levels as ordered.

Interview with LPN #2 and administrative staff #1 and #2 on 8/15/13 at 2:30 PM indicated client #2 saw the endocrinologist on 8/15/13. Administrative staff #1 indicated LPN #2 did not know she was to take client #2 to the doctor's appointment as the DHS was to take the client but the DHS had resigned the morning of 8/15/13. LPN #2 indicated client #2's blood sugar level was 432 at the doctor's office and the client was given 15 units of Novolog 70/30 at the doctor's office. When asked what documents were taken to the appointment, administrative staff #1 indicated LPN #2 was not able to take the blood sugar levels as they were not available. LPN #2 indicated she took the lunch time blood sugar level readings only. LPN #2 indicated she did not take the AM readings, PM and bed time readings for the doctor to review. LPN #2 indicated she took client #2's menu for today 8/15/13 and the client's lunch on hand for 8/15/13. LPN #2 indicated she had client #2's food journal but the doctor did not look at it. When asked if the endocrinologist had been made aware of the client's hospitalization, administrative staff #1 indicated the doctor was told of the hospitalization. LPN #2 indicated the hospital was told to call the endocrinologist upon admission. LPN #2 indicated the hospital did not call him. LPN #2 stated client #2's doctor "removed" the sliding scale and placed client #2 on 25 units Novolog at breakfast and 20 units at supper. LPN #2 indicated nursing staff were to assess clients within 24 hours of discharge from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 149}	Continued From page 34	{W 149}		

the hospital. Administrative staff #1 indicated the previous nurse did not do a timely assessment of client #2. Administrative staff #2 stated "An investigation was done to determine if an investigation was to be done. They said no. When came to me I told them this should be investigated as neglect."

Interview with administrative staff #1 on 8/15/13 at 2:30 PM and on 8/16/13 at 10:50 AM indicated nursing staff would send the medication/order change form to the group home when clients' medications were changed. Administrative staff #1 indicated the previous nurse did not do a timely assessment of client #2. Administrative staff #1 stated "An investigation was done to determine if an investigation was to be done. They said no. When came to me I told them this should be investigated as neglect." Administrative staff #1 indicated nursing staff had 24 hours to assess a client once discharged from the group home per the facility's policy. Administrative staff #1 indicated an investigation was conducted in regard to the 8/5/13 allegation of neglect in regard to client #2's discharge from the hospital/physician's orders. Administrative staff #1 indicated the group home checked client #2's blood sugar level at lunch and administered client #2's insulin per the sliding scale as needed on 8/3, 8/4, 8/5 and 8/6/13. Administrative staff #1 indicated the group home staff called the on-call nurse as the orders sent home with the client were different from what the client had received prior to the hospitalization. Administrative staff #1 stated the on-call nurse "walked them through writing the orders on the MAR." Administrative staff #1 indicated this information was not documented in the investigation. Administrative staff #1 stated LPN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 149}	Continued From page 35	{W 149}		

#1 indicated on 8/2/13, "She (LPN #1) was not going to the group home at 4:00 PM." Administrative staff #1 indicated LPN #1 was no longer employed with the facility.

2. A review of client #3's record was conducted at the facility's administrative office on 8/13/13 at 2:30 P.M.. Review of client #3's record indicated a "Nutritional Assessment" dated 6/5/13 which indicated: "Weight: 159 lbs (pounds)...Ideal Body Weight: 169-186...Diet Order: Regular Diet." Review of client #3's "Cumulative Medical" record indicated the following:

Medical notation dated 7/25/13: "...Multiple areas of colon wall thickening, possible mass or colitis. Weight loss continues now at 152.5 pounds, down additional 8 1/2 pounds. Strongly recommend colonoscopy/lower GI testing...Of note came up medicaid ineligible today...Also assess increase calories."

Medical notation dated 7/31/13: "Called [Physician name] spoke to [Nurse name] orders for nutritional supplement...to have weights checked weekly."

Medical notation dated 7/31/13: "Late entry...Appointment to be scheduled for follow-up visit with [Physician name] re: weight loss recommendations for colonoscopy/lower GI testing further evaluations."

Medical notation dated 8/2/13: "[Client #3 Aunt name] called this writer...stated nobody is doing anything about his weight loss...."

Medical notation dated 8/7/13: "Consumer has maintained a weight between 157-159 pounds for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 149}	Continued From page 36	{W 149}		

the past three months. Consumer consume 100% of all meals and ensure supplement. Weekly weights will continue."

Client #3's 2012 and 2013 Weight Chart indicated the following (not all inclusive):

-May 2012 209 pounds
-June 2012 219 pounds
-July 2012 188 pounds
-August 2012 183 pounds
-September 2012 183 pounds
-October 2012 176 pounds
-November 2012 177 pounds
-December 2012 169 pounds
-January 2013 167 pounds
-February 2013 178 pounds
-March 2013 176 pounds
-April 2013 159 pounds
-May 2013 157 pounds
-June 2013 159 pounds
-July 2013 159 pounds.

Client #3's May 2013 Weight Management risk plan indicated "...[Client #3] had a history of weight loss. [Client #3] was on a portion control diet. [Client #3] is now on a regular diet. Baseline: [Client #3's] current weight is 169. His ideal body weight should be between 165-205." The risk plan indicated "Staff is to encourage [client #3] to eat all his food and encourage him to have seconds. Staff are to monitor [client #3's] food intake by size and report and document his food intake on tracking sheet. Staff should call the Community Services Nurse if [client #3's] food intake is less than 1/4 of the entire meal at every meal." The risk plan indicated the tracking sheets were to be submitted to the Service Coordinator every Monday, and the facility's nurse would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 149}	Continued From page 37	{W 149}		

review the tracking sheets at least monthly. The risk plan indicated client #3 would be weighed once a week at the day program. The risk plan indicated the Health & Safety Tech would monitor the weights and send them into the nurse weekly. The 5/2013 risk plan indicated "...If plus or minus 3lbs (pounds) in a week the Community Services Nurse will evaluate the findings..." and contact the client's doctor. The risk plan indicated the nurse would keep a record of client #3's food consumption.

A review of the Director of Nursing services client weights spread sheet no date noted was conducted on 8/14/13 at 1:30 P.M.. Review of the spreadsheet indicated client #3 was weighed monthly. The spread sheet neglected to indicate client #3 was weighed weekly.

An interview with the Director of Nursing services (DON) was conducted at the facility's administrative office on 8/14/13 at 2:30 P.M.. When asked how often client #3 was weighed, the DON stated "Monthly." When asked if there was documentation to indicate client #3 was weighed weekly, the DON stated "He is weighed at the day program and when they weigh him they send the information to me and I put the information on my spread sheet." When asked if her documented spread sheet indicated client #3 was weighed weekly, she stated "No, monthly." When asked if client #3's weight loss risk plan had been addressed since his 8.5 pound weight loss noted on 7/25/13, the DON stated "I'm not sure." When asked if the doctor or nutritionist had been contacted after the noted weight loss, the DON stated "I'm not sure."

The facility's policy and procedures were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 149}	Continued From page 38 reviewed on 8/12/13 at 2:33 PM. The facility's 2/15/12 policy entitled Policy For Handling Cases of Neglect And Abuse indicated "...I. The Arc Northwest Indiana prohibits all abuse, neglect and exploitation of our clients...III. All allegations of abuse, neglect, humiliation or exploitation will be investigated per The Arc Northwest Indiana's investigation process, while protecting the individual." The facility's policy indicated "Neglect - is defined as failure to consider and provide for the safety or care of the client and anticipate and remedy the placing of a client in a situation that poses a threat to his/her health and well-being. Examples include, but are not limited to ...medical care/treatment,...." This deficiency was cited on 7/3/13. The facility failed to implement a systemic plan of correction to prevent recurrence.	{W 149}		
W 154	9-3-2(a) 483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on 1 of 1 allegation of abuse and/or neglect reviewed, the facility failed to initiate an investigation in regard to an allegation of possible neglect regarding a medication error, when the incident occurred and/or failed to conduct a thorough investigation into the allegation/incident for client #2. Findings include:	W 154		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 154	Continued From page 39	W 154		

The facility's reportable incident reports, Incident/Accident Reports (IAR) and/or investigations were reviewed on 8/12/13 at 3:23 PM. The facility's 8/5/13 reportable incident report indicated "Director of Health Services (DHS) reviewed hospital discharge orders for [client #2], which instructed that his blood sugar levels were to be checked prior to lunch to determine if insulin coverage was needed. The nurse failed to follow up and train day program staff on the new doctor orders. Which resulted in [client #2] not having his blood sugar checked appropriately on 8/5/13 and 8/6/13 (sic). The nurse immediately went to the East center (facility owned day program) to provide Novolog insulin, ensured that the glucometer and test strips were available, transcribed the orders on the MAR (medication administration record), and trained the health and safety tech on the new orders. The Director of Health Services will follow up with [client #2's] primary care physician."

The facility's 8/9/13 follow-up report indicated "...3. What measures are being implemented to prevent this from happening again? Training was done with the nurses which consisted of thorough review of all discharge hospital orders and ensure all orders are carried out."

The facility's 8/5/13 IAR indicated LPN #1 was the nurse involved in the error.

The facility's 8/8/13 Investigation Fact Sheet Summary and Conclusion indicated the DHS conducted an investigation in regard to possible neglect. The facility's investigation indicated "[Client #2] was discharged home on Friday 8-2-13. Discharge hospital orders were not carried out; nurse did not visit client for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 154	Continued From page 40	W 154		

post-hospital D/C (discharge) assessment within 24 (hours) as per policy. Nurse failed to follow-up and train day program staff on the new orders from M.D. (medical doctor)." The facility's 8/8/13 investigation indicated "The allegation is true." The facility's investigation indicated LPN #1 was a nurse from a temporary nurse staffing agency, and the facility did not report the allegation to the staffing agency until 8/13/13. The facility's witness statements indicated LPN #1 was interviewed on 8/13/13, administrative staff #3 on 8/15/13, and Service Coordinator #1 was interviewed on 8/14/13.

Administrative staff #3's 8/15/13 witness statement indicated they were notified of a medication error by the DHS on 8/6/13. The witness statement indicated "The Nursing Director explained that the Service Coordinator gave permission to the hospital to discharge consumer and did not inform the Residential Nurse about the consumer. She stated that the consumer did not receive his insulin or glucose tests for the group home and day service facility. She stated she was going to look further and get back to me with an update. I told her that based on what she told me so far it looked like a med error, and process error...An investigation was not initiated right away because I (administrative staff #3) did not have knowledge of possible neglect of the temp nurse knowing about the discharge of this consumer. Otherwise an internal investigation would have been initiated earlier,...."

Service Coordinator (SC) #1's 8/14/13 witness statement indicated on 8/2/13 at 3:30 PM, SC #1 received a phone call indicating client #2 would be discharged from the hospital. The witness

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 154	Continued From page 41 statement indicated SC #1 requested the discharge information and physician orders from the hospital and provided them the fax number to the facility. The witness statement indicated SC #1 then told LPN #1 of the discharge. The witness statement indicated the information arrived by fax at 4:15 PM and she gave the information to the nurse for review. The witness statement indicated "...She stated that it was okay and I (SC #1) contacted the Hospital Social Worker and scheduled transportation w/ (with) [name of ambulance company]." LPN #1's 8/13/13 witness statement indicated she was not told of client #2's discharge from the hospital on 8/2/13. The witness statement indicated "...staff reported it was rumors client would be returning Fri (Friday). On Monday morning this nurse was informed client was home from the hospital. This nurse then follow-up (sic) with paperwork and clarified MD orders, orders were sent to the group home, workshop, area manager, service coordinators via email. The client was not seen within 24 hours from hosp (hospital) discharge and although orders were sent to workshop (sic) staff did not follow through with orders. According to DON (Director of Nursing) I was to be disciplined due to neglect of client according to policy and procedure, I never received the proper training, I never received a policy and procedure handbook. I no longer feel comfortable working for a company that has no structure and puts my nursing license in jeopardy." The facility's 8/8/13 investigation indicated the facility failed to interview day program staff and group home staff in regard to the error/incident, and/or failed to initiate an investigation for possible neglect on 8/5/13 once the error/incident was identified.	W 154		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 154	Continued From page 42	W 154		

Interview with administrative staff #2 on 8/12/13 at 4:15 PM when asked if there was an investigation for the 8/5/13 incident, administrative staff #2 indicated she had been told no investigation was completed as it was not seen as an allegation of neglect.

Interview with administrative staff #1 on 8/15/13 at 2:30 PM and on 8/16/13 at 10:50 AM indicated nursing staff would send the medication/order change form to the group home when clients' medications were changed. Administrative staff #1 indicated the previous nurse did not do a timely assessment of client #2. Administrative staff #1 stated "An investigation was done to determine if an investigation was to be done. They said no. When came to me I told them this should be investigated as neglect." Administrative staff #1 indicated nursing staff had 24 hours to assess a client once discharged from the group home per the facility's policy. Administrative staff #1 indicated an investigation was conducted in regard to the 8/5/13 allegation of neglect in regard to client #2's discharge from the hospital/physician's orders. Administrative staff #1 indicated the group home checked client #2's blood sugar level at lunch and administered client #2's insulin per the sliding scale as needed on 8/3, 8/4, 8/5 and 8/6/13. Administrative staff #1 indicated the group home staff called the on-call nurse as the orders sent home with the client were different from what the client had received prior to the hospitalization. Administrative staff #1 stated the on-call nurse "walked them through writing the orders on the MAR." Administrative staff #1 indicated this information was not documented in the investigation. Administrative staff #1 stated LPN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

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W 154	Continued From page 43 #1 indicated on 8/2/13, "She (LPN #1) was not going to the group home at 4:00 PM." Administrative staff #1 indicated LPN #1 was no longer employed with the facility.	W 154		
W 157	9-3-2(a) 483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. This STANDARD is not met as evidenced by: Based on interview and record review for 1 of 1 allegation of abuse and/or neglect reviewed, the facility failed to implement recommended corrective action to ensure all group home nurses were retrained in regard to hospital discharges for client #2. Findings include: The facility's reportable incident reports, Incident/Accident Reports (IAR) and/or investigations were reviewed on 8/12/13 3:23 PM. The facility's 8/5/13 reportable incident report indicated "Director of Health Services (DHS) reviewed hospital discharge orders for [client #2], which instructed that his blood sugar levels were to be checked prior to lunch to determine if insulin coverage was needed. The nurse failed to follow up and train day program staff on the new doctor orders. Which resulted in [client #2] not having his blood sugar checked appropriately on 8/5/13 and 8/6/13 (sic). The nurse immediately went to the East center (facility owned day program) to provide Novolog insulin, ensured that the glucometer and test strips were available,	W 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 157	Continued From page 44 transcribed the orders on the MAR (medication administration record), and trained the health and safety tech on the new orders. The Director of Health Services will follow up with [client #2's] primary care physician." The facility's 8/9/13 follow-up report indicated "...3. What measures are being implemented to prevent this from happening again? Training was done with the nurses which consisted of thorough review of all discharge hospital orders and ensure all orders are carried out." The facility's 8/5/13 IAR indicated LPN #1 was the nurse involved in the error. The facility's training records were reviewed on 8/12/13 at 4:00 PM. The facility's 8/5/13 Individual Client Training Forms indicated the DHS completed training procedures for discharge, reviewing discharge orders, clarifying orders and following up with treatment and medication changes with LPN #1 and LPN #2 of the group homes. Interview with administrative staff #2 on 8/12/13 at 4:15 PM indicated the DHS retrained 2 of 4 group home nurses. Administrative staff #2 indicated he DHS only trained the nurses who worked with the Fourteenth Lane group home. Administrative staff #2 stated LPN #1 and LPN #2 were not the only nurses who worked on call as LPN #1 was a "temporary" (part time) nurse and LPN #2 was a full time nurse. The facility failed to train all nurses in regard to discharge orders to ensure continuity of care with clients. 9-3-2(a)	W 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 189	Continued From page 45	W 189		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, interview and record review for 1 of 2 sampled clients (#2), the facility failed to ensure all group home staff were trained in regard to the client's desensitization plan for the use of a gait belt or walker. Findings include: The facility's reportable incident reports, Incident/Accident Reports (IAR) and/or investigations were reviewed on 8/12/13 3:23 PM. The facility's reportable incident reports, IARs and/or investigations indicated on 7/10/13 "This Service Coordinator (SC) (SC #1) received a phone call from the group home at approximately 8:30 AM on 7/10/13 stated that consumer [client #2] appeared lethargic and his gait was unsteady (sic). Staff were directed to check his blood glucose level. It was 210. The nurse directed staff to transport [client #2] to [name of hospital] in [name of city], In. Blood tests and CT scan yielded no significant findings. [Client #2] was not admitted to the hospital, he was discharged from the ER (emergency room) at 12:30 PM on 7/10/13. No new medications, prescriptions for a walker provided by the ER physician. At 1:00 PM Residential staff transported consumer [client #2] from the hospital to the group home after ER discharge. Upon	W 189		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 189	Continued From page 46	W 189		

disembarking the vehicle (at group home) [client #2's] body shook uncontrollably. Staff assisted [client #2] to the ground, no injury noted. 911 called...[Client #2] was transported back to the ER via ambulance.

At 2:00 PM, the ER physician noted low Depakote (seizure) levels from previous work (taken at initial visit). Consumer [client #2] was given Zalerate 100ml (milliliters) intravenously while in the ER to bring his depakote levels up. [Client #2] was discharged from the ER at 5:00 PM on 7/10/13. No new medications, prescription for a walker written. The ER physician recommended that [client #2] follow-up with his primary care physician (PCP) and that [client #2] continue to take his current medications as prescribed."

The facility's 7/19/13 follow-up report indicated client #2 saw his PCP. The follow-up report indicated client #2's "...increasing unsteadiness and uncoordinated movements are correlated with his diagnosis of Parkinson's Disease (disorder of the brain that lead leads to tremors and difficulty walking). It is recommended he follow-up with a neurologist...." The follow-up report also indicated client #2 would see a physical therapist (PT) and occupational therapist (OT) for the need/use of adaptive equipment.

During the 8/12/13 observation period between 5:15 PM and 7:10 PM, at the group home, client #2 did not wear a gait belt and/or utilize a walker. Staff #1 and #2 did not implement any desensitization training with client #2.

Client #2's record was reviewed on 8/12/13 at 5:22 PM and on 8/13/13 at 1:10 PM. Client #2's 7/10/13 hospital records indicated client #2 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 189	Continued From page 47	W 189		

seen in the ER on 7/10/13. The 7/10/13 ER note indicated client #2's diagnoses included, but were not limited to, "Uncoordinated movements, Parkinson Disease, and Type II diabetes mellitus without control." The ER note indicated client #2 was to follow-up with his PCP in 2 days and a "roller walker" was ordered for client #2.

Client #2's Cumulative Medical Records and physician orders indicated the following (not all inclusive):

-7/10/13 "Sent to E.R. for eval (evaluation) & tx (treatment) d/t (due to) staff reporting (change) in medical condition (unsteady gait)."

-7/10/13 "Eval @ (at) [name of hospital] DX: uncoordinated movements, Parkinson Disease, Type II DM (diabetes mellitus), convulsions. Labs & CT head done. Rx (prescription) for walker. Appt (appointment) (with) [name of doctor] (neurologist) 7-23-13 @ 10 AM, Appt OT/PT eval - 7-19-13 @ 9 AM."

-7/11/13 "Gait belt DX (diagnosis): unsteady gait."

-7/23/13 "...New Neuro pt (patient) sent here at the request of the DON (Director of Nursing) at The Arc. Pt has been diagnosed with Parkinson Disease. Pt was recently seen in the ER at [name of hospital] for full body tremors per the social worker here with him today. Pt is on Depakote but he doesn't have a diagnoses (sic) of seizures." The 7/23/13 note indicated Carbidopa-Levodopa (Parkinson Disease) 25-100 milligrams daily with meals. The note indicated the facility was to start with breakfast for 1 week, then 1 with breakfast and lunch for 1 week, then 1 with each meal. The neurology report indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 189	Continued From page 48	W 189		

the Neurologist ordered an EEG awake and asleep for client #2. The report also indicated client #2 was to return in 6 weeks or as needed. The 7/23/13 report indicated client #2 was given a diagnosis of Seizure.

Client #2's 7/19/13 PT and OT evaluation indicated client #2 was a fall risk and should exercise safety around sharp objects or moving objects. The assessment indicated client #2 was "...unable to follow 1 step commands consistantly (sic)...." The PT assessment indicated "Current Home Program: pt is unable to follow any exercises. No HEP (home exercise program) provided/Pt inappropriate...Recommendation/Plan OT Plan **Requires OT follow Up**: No PT is not appropriate for OT services at this time. Recommend 24 hour supervision in structured environment. This patient will be seen for skilled occupational therapy for optimal return to independence with meaningful occupations...."

Client #2's 7/2013 risk plan for Parkinson's Syndrome indicated "Staff will to monitor [client #2] while ambulating (sic)...Staff will make sure that [client #2] and the bathroom floor are fully dried after showering/bathing...Staff will make sure walkways are clear of obstacles and tripping hazards...[Client #2] has been prescribed a gait belt and walker. However, at this time he is combative in using the gate (sic) belt and the walker. A desensitization plan has been developed please see this plan...."

Client #2's 7/13 behavior plan indicated "A gait belt and walker has (sic) been recommended for [client #2] to reduce these falls. He is extremely resistant to these items. A desensitization plan

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 189	Continued From page 49 for this is being added to his plan. [Client #2] is also resistant to some medical appointment desensitization for appointment is also be in added (sic)." Client #2's 7/13 behavior plan indicated the desensitization plans for the gait belt and the walker were to be run/implemented 5 times a day the group home and at the day program. Interview with administrative staff #2, SC #1 and #2, and the DHS on 8/14/13 at 1:50 PM indicated client #2 did not want to wear his gait belt and/or use a walker. SC #2 indicated client #2 had a desensitization plan for using his walker and gait belt. SC #2 indicated he had trained the day program staff in regard to the desensitization plan, but he had not trained the group home staff in regard to the behavior plan. 9-3-3(a)	W 189		
{W 210}	483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. This STANDARD is not met as evidenced by: Based on interview and record review for 1 of 3 sampled clients (#2) and for 1 additional client (#3), the clients' interdisciplinary teams failed to reassess client #2's diabetic diet in regard to the client's low and/or high blood sugar levels to see if there were any correlation, and to reassess client #3's weight loss.	{W 210}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 210}	Continued From page 50	{W 210}		

Findings include:

1. The facility's reportable incident reports, Incident/Accident Reports (IAR) and/or investigations were reviewed on 8/12/13 at 3:23 PM. The facility's reportable incident reports, IARs and/or investigations indicated the following:

-7/10/13 "This Service Coordinator (SC) (SC #1) received a phone call from the group home at approximately 8:30 AM on 7/10/13 stated that consumer [client #2] appeared lethargic and his gait was unsteady (sic). Staff were directed to check his blood glucose level. It was 210. The nurse directed staff to transport [client #2] to [name of hospital] in [name of city], In. Blood tests and CT scan yielded no significant findings. [Client #2] was not admitted to the hospital, he was discharged from the ER (emergency room) at 12:30 PM on 7/10/13...At 1:00 PM Residential staff transported consumer [client #2] from the hospital to the group home after ER discharge. Upon disembarking the vehicle (at group home) [client #2's] body shook uncontrollably. Staff assisted [client #2] to the ground, no injury noted. 911 called...[Client #2] was transported back to the ER via ambulance.

At 2:00 PM, the ER physician noted low Depakote (seizure) levels from previous work (taken at initial visit). Consumer [client #2] was given Zalerate 100ml (milliliters) intravenously while in the ER to bring his depakote levels up. [Client #2] was discharged from the ER at 5:00 PM on 7/10/13. No new medications, prescription for a walker written. The ER physician recommended that [client #2] follow-up with his primary care physician (PCP) and that [client #2] continue to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 210}	Continued From page 51	{W 210}		

take his current medications as prescribed."

-7/11/13 "[Client #2] came into the workshop at 9:00 AM with signs of hyperglycemia (high blood sugar) which included shakiness and combativeness. Health & (and) Safety (H&S) tech tested [client #2's] sugar level which was 369. [Client #2] was given water and H&S Tech contacted Residential Nurse and left message with Director of Health Services. [Client #2] was closely monitored by staff and H&S Tech for any changes. [Client #2's] level was checked again and tested at 463. Facility Director called 911 and EMT (emergency medical technician) arrived and checked [client #2's] levels which tested at 476. [Client #2] was then transported to [name of hospital]."

-7/26/13 "Consumer [client #2] was non-responsive during a routine bed check. Staff checked [client #2's] glucose and it was in the 40's, and the Nurse was notified. 911 was called and [client #2] was transported to [name of hospital]."

-7/31/13 "[Client #2] was at [name of hospital] in [name of city], Indiana for a scheduled EEG on 7/31/13. During the procedure [client #2] began to show signs of hypoglycemia (low blood sugar). His sugar dropped below 30. [Client #2] was rushed to [name of hospital] emergency room. His blood sugar was stabilized and he was admitted to the hospital for further observation."

The facility's 7/31/13 IAR indicated client #2 would not respond to staff when they called his name. The IAR indicated the client was taken to the ER where it was determined his blood sugar level was below 30 and he was admitted to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 210}	Continued From page 52	{W 210}		

hospital.

Client #2's record was reviewed on 8/12/13 at 5:22 PM and on 8/13/13 at 1:10 PM. Client #2's 7/10/13 hospital records indicated client #2 was seen in the ER on 7/10/13. The 7/10/13 ER note indicated client #2's diagnoses included, but were not limited to, "Uncoordinated movements, Parkinson Disease, and Type II diabetes mellitus without control."

Client #2's 7/31/13 History and Physical (H&P) indicated client #2 was seen in the ER for the chief complaint of Hypoglycemia. The H&P indicated "...patient was reportedly developing diaphoresis (excessive sweating commonly associated with shock and other medical emergency conditions) and restless while having EEG done today; patient was noted to have low blood sugar. Hypoglycemia has been recurrent past few days; had 3 ER visits at local ER...."

An 8/2/13 After Visit Summary indicated client #2 was discharged back to the group home on 8/2/13. The summary indicated client #2 was to follow up with his PCP in 1 week and the nephrologist in 5 weeks with labs to be done in 4 weeks. The 8/2/13 summary indicated client #2 was placed on a sliding scale. The 8/2/13 summary indicated "Other Prescriptions... Novolog Mix 70/30 Flex pen inject 5 units into the skin 2 (two) times daily before meals" and "insulin apart (sliding scale insulin coverage) Novolog Flex Pen inject three times daily with meals BS (blood sugar) 150-199 1U (unit) SQ (subcutaneous)
200-249-2U SQ
250-300-3U SQ
301-349-4U SQ

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{W 210}	Continued From page 53 350-400-5U SQ > (more than) 400-6 units SQ call MD (medical doctor)." The 8/2/13 Patient Instructions indicated the facility was to monitor client #2's glucose levels 4 times daily at meals and at bedtime (HS). Client #2's Cumulative Medical Records and physician orders indicated the following (not all inclusive): -7/10/13 "Sent to E.R. for eval (evaluation) & tx (treatment) d/t (due to) staff reporting (change) in medical condition (unsteady gait)." -7/10/13 "Eval @ (at) [name of hospital] DX: uncoordinated movements, Parkinson Disease, Type II DM (diabetes mellitus), convulsions. Labs & CT head done. Rx (prescription) for walker. Appt (appointment) (with) [name of doctor] (neurologist) 7-23-13 @ 10 AM, Appt OT/PT eval - 7-19-13 @ 9 AM." -7/15/13 (8:25 AM) "Blood Sugar (increase) 419. Status update given to [name of endocrinologist] office- Client taken to Dr's (doctor's) office- orders rec'd (received) to (increase)- a.m. insulin dose to 20 units and p.m. dose to 10 units and return to office in 4 weeks- appt scheduled 8-15-13 @ 10:30 AM." -7/22/13 "Rec'd phone call from staff on 7-20-13 @ 7:15 pm- reports client BS 21 glucagen subcut (subcutaneous) given - unable to wake client up- breathing/snoring loud; sweating profusely- informed to call 911 immediately. EMS admin. IV Dextrose as per staff BS (increased) to 100 - client aroused- no ER transport needed - informed to give dinner, hold P.M. insulin dose @	{W 210}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

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{W 210}	Continued From page 54	{W 210}		

this time; monitor condition; repeat BS @ 10 PM & call on-call nurse (with) results. At 10 PM- blood sugar 265- Continue to monitor client throughout night."

-7/23/13 "Spoke w/ (with) [name of endocrinologist] re: (referring to) elevated blood sugars over 300 and no return phone calls when Dr. paged; orders rec'd to continue to call [name of endocrinologist] for BS > 300 via pager or cell phone; insulin increased to 25 units @ bkfst (breakfast) and 20 units (with) dinner & F/U (follow-up) for appt next wk (week) (call for appt)."

-7/23/13 Faxed note indicated "1.) Continue to call [name of endocrinologist] for blood sugars > 300. His cell number is [number listed] or pager [number listed]. 2. Increased Novelin 70/30 to 25 units before breakfast & 20 units before dinner. Please make sure patient eats when you give insulin." On the bottom of the attached order sheet, the facility's nurse sought clarification in regard to the medication as it was to be Novolog 25 before breakfast and 20 units at supper.

-7/23/13 (5:30 PM) "While visiting home (this writer) (Director of Health Services)- client's BS 45 informed to hold p.m. insulin- 1 cup milk, slice of bread & serving of rice given prior to leaving home for outing. Staff informed to obtain BS during outing (with) any s/s (signs and symptoms) of hypo/hyperglycemia & repeat BS when return to home."

-7/23/13 (8:20 PM) "Client (without) incident @ outing. B.S. 53 when returned home- sub Q (subcutaneous) glucagen given per staff; ate supper @ outing around 7-7:15 pm- informed to repeat BS in 1 hour- call w/results. 9:25 PM BS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{W 210}	Continued From page 55	{W 210}		

up to 98 informed to give HS snack graham crackers & cup of milk."

-undated note "In case of emergency go to the emergency room of the hospital closest to you and have [name of endocrinologist] paged [pager number listed] wait for two beeps then place in your number with a touch tone phone. Then wait two beeps again. Then hang up. [Name of endocrinologist] will return your call. [Name of Endocrinologist] wants to also be notified about B/S over 300...Low BS- Milk or juice."

-7/26/13 "Rec'd phone call from staff @ 5:40 a.m. S 47- client sweating profusely; c/o (complaints of) stiff muscles - informed to call 911- adm (administer) sub Q glucagen. This writer (DHS) arrived @ home approx (approximately) 6:15 a.m. - EMS present - BS 42 per EMS; IV dextrose given- [client #2] cont. (continue) to sweat profusely/EMS attempting to arouse - repeat BS per EMS after IV dextrose (decreased) 30's - taken to E.R. for evaluation."

-7/26/13 Novolog 70/30 ordered 15 units with breakfast and 10 units with dinner.

-7/31/13 Client #2 went to hospital for EEG testing and showed signs of hypoglycemia. The note indicated client #2 was transported to the ER and admitted with a blood sugar below 30. The note indicated client #2 was to have a kidney ultrasound and blood work completed.

Client #2's 8/5/13 Medication Change Form indicated client #2 had a new medication order/change. The 8/5/13 form indicated "Give Novolog 70/30 5 units 2xs (times) a day before breakfast and dinner subq. Give Insulin apart

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 210}	Continued From page 56	{W 210}		

Novolog 3xs a day with meals subq if BS reading is
150-199 give 1unit
200-249 give 2units
250-300 give 3units
301-349 give 4 units
350-400 give 5 units.
If BS is greater than 400 give 6units (sic) and call Nurse/MD...."

The 8/5/13 change form and/or Cumulative Medical Record indicated the facility neglected to obtain clarification in regard to when the doctor and/or endocrinologist wanted to be notified as the 7/23/13 order indicated at 300 and the 8/5/13 order indicated 400.

Client #2's August 2013 Medication Administration Record (MARs) indicated the facility monitored client #2's blood sugar levels in the morning, lunch, PM (evening before dinner) and at bed time. Client #2's 8/13 MAR indicated the following blood sugar levels (not all inclusive):

-8/2/13 bed time 328
-8/3/13 lunch 444
-8/3/13 bed time 312
-8/4/13 lunch 352
-8/4/13 bed time 341
-8/5/13 morning 304
-8/5/13 evening/dinner 342
-8/6/13 evening/dinner 310
-8/8/13 evening/dinner 321
-8/10/13 lunch 334
-8/10/13 evening/dinner 435
-8/10/13 bed time 371
-8/11/13 lunch 344
-8/11/13 evening/dinner 439
-8/11/13 bed time 352.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 210}	Continued From page 57	{W 210}		

The facility's Residential Services Pager Review was reviewed on 8/13/13 at 1:40 PM. The facility's pager records indicated the following in regards to client #2's blood sugar levels/readings:

-7/8/13 302 at 5:55 PM, client #2 was "unsteady and shaking."
-7/18/13 352 at 8:07 AM
-7/18/13 353 at 6:12 PM, and then 379 with a different glucometer.
-7/22/13 408 at 5:53 PM
-7/24/13 330 at 9:18 PM
-7/27/13 487 at 6:30 PM "Give p.m. insulin dose feed dinner. Call back w/results in 2-21/2 hours after eating. 10 pm BS going down 337."
-7/28/13 398 at 6:20 PM "Informed to give p.m. insulin dinner re(check) in 2/1/2-3 hrs (hours). Call w/results."
-8/2/13 328 at 10:31 PM
-8/3/13 456 at 10:41 AM
-8/3/13 444 at 1:39 PM
-8/4/13 341 (no time documented)
-8/5/13 304 at 6:50 AM.

Client #2's pager log and/or Cumulative Medical Record indicated the facility did not inform the doctor/endocrinologist of client #2's high blood sugar readings over 300 prior to 8/5/13 and/or over 400 after 8/5/13.

Client #2's undated typed sheet indicated client #2 was to carry a sack lunch and a snack to the day program daily, document what was sent and what the client ate.

Client #2's 8/2013 food journal book indicated client #2 received an 1800 calorie ADA (diabetic) diet. Client #2's 8/2013 menus indicated "Hot

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 210}	Continued From page 58	{W 210}		

lunch Eat at workshop" on 8/8/13, 8/9/13, 8/12/13, 8/15/13, 8/16/13, 8/19/13, 8/22/13, 8/23/13, 8/26/13, 8/29/13 and 8/30/13.

Client #2's 8/2013 food journal book indicated the following menu/food items sent for the client's lunch on the following days:

-8/8/13 Three ounces of chicken, 1/2 cup macaroni and cheese, 1/2 cup potatoes, 1 slice of bread, orange slices and water.

-8/9/13 Three ounces of meat, 1/2 cup of noodles, garlic bread, 1/2 cup of peas and carrots, 1 cup mandarin oranges, water and 8 ounce cup of milk.

-8/11/13 Three ounces of polish sausage, 1/2 cup dirty rice, 1/2 bun, salad, fruit cup, yogurt and water.

-8/12/13 2 sliced hot dogs, 1 slice of bread, 1 serving of rice, 1 serving of salad, fruit cup, graham crackers and 16 ounces of water.

Client #2's 6/5/13 Annual Nutritional Assessment indicated "...Client on Diabetic 1800 calorie meal plan as ordered by MD. Staff monitor carbohydrate counting at mealtime. Continue to monitor blood sugar." The facility failed to have client #2's 1800 calorie ADA diet re-assessed in regard to the client's high/low blood sugar levels to ensure the menus did not contain a lot of starches, carbohydrates and/or natural sugars which could affect client #2's blood sugar levels.

Client #2's 8/7/13 Diabetic (risk) Plan indicated "Menus are developed and sent to the Nutritionist for review for approval and revisions." The 8/7/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{W 210}	Continued From page 59	{W 210}		

risk plan indicated client #2 was to carry a sack lunch daily.

Client #2's 2/28/13 IPP indicated client #2's interdisciplinary team (IDT) met on 7/10/13, 7/11/13 and on 7/19/13. Client #2's above mentioned IDT notes and/or the client's 2/28/13 IPP indicated the IDT failed to meet since client #2 was discharged from the hospital on 8/2/13 to review and/or re-assess client #2's 1800 calorie ADA diet menus/food journals in regard to the client's high/low blood sugar readings/levels to determine if there was any correlation.

Interview with the dietician on 8/13/13 at 1:44 PM, by phone, indicated she last assessed client #2 in the month of May 2013. When asked if the facility had contacted her in regard to the client's elevated and low blood sugar levels and his diet, the dietician stated "No." The dietician indicated she was not aware client #2 had been hospitalized until she came to the facility to do an inservice training. When asked if she was aware client #2 was diagnosed with Chronic Kidney Disease stage 3, the dietician stated "No." The dietician indicated she was not aware of any insulin changes from the 7/31/13 hospitalization. The dietician stated she would "Definitely want to be notified in regard to low blood sugar or change in medication, diet changes to go back and re-evaluate client." The dietician stated she should be made aware of any "abnormal readings" which were high or low. The dietician stated she did not attend the IDT meetings but had discussed the client's "Plan of Care" in the past. The dietician indicated she had not communicated with the Endocrinologist in regard to the client's menus. The dietician indicated she reviewed and approved the client's menus that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 210}	Continued From page 60	{W 210}		

were sent to her. The dietician indicated the facility had not asked her to re-assess client #2.

Interview with administrative staff #2, SC #1 and #2, and the DHS on 8/14/13 at 1:50 PM indicated client #2 was hospitalized on 7/31/13 for low blood sugar level reading when the client was at the hospital for an EEG. The DHS indicated client #2 was discharged on 8/2/13 and placed on a sliding scale. The DHS could not locate the order for the changes of the insulin and/or doctor notification. The DHS stated client #2's blood sugar levels were "up and down." The DHS indicated the dietician was aware of client #2's low and high blood sugar level readings. The DHS indicated client #2 started carrying sack lunches July 28, 2013 versus purchasing hot meals at the workshops. The DHS and SC #1 indicated they had not reviewed the menus to ensure all lunches had been reviewed and/or approved by the dietician. SC #1 indicated the 8/2013 menu was approved by the dietician when client #2 was still eating at the workshop. SC #1 indicated no one had resubmitted menus for the days the menu called for eating at the workshop. The DHS and DS #1 indicated no one reviewed the menus since the dietician approved them. The DHS, SC #1 and administrative staff #2 indicated the dietician had not attended any IDT meetings. SC #1 stated "No one thought of inviting the dietician to the program (meetings)." The DHS indicated client #2's Endocrinologist was made aware of client #2's low and high blood sugars. The DHS and SC #1 indicated the IDT had not re-assessed client #2's diet/food journal/consumption in regard to the client's low and/or high blood sugar levels.

Interview with the Endocrinologist on 8/15/13 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 210}	Continued From page 61	{W 210}		

1:45 PM, by phone, indicated client #2 was a patient he followed. The Endocrinologist indicated he saw client #2 at his office on 8/15/13. The doctor indicated client #2's blood sugar level over 400 in his office. The Endocrinologist indicated when he asked the nurse what client #2's morning blood sugar reading was, the Endocrinologist indicated the nurse could not tell him. The Endocrinologist stated he had written orders for client #2's blood sugar levels to be monitored, but the facility did not bring all the readings with them except the "PM readings." The doctor indicated he made some changes in regard to the client's insulin on 8/15/13. The Endocrinologist indicated the nurse told him the client's PCP was also seeing the client for his diabetes. The doctor stated he told them the PCP could follow his diabetes and if his PCP "could not handle" they could bring the client back to him. When asked if he was aware of client #2's hospitalization, the Endocrinologist asked when client #2 was hospitalized and why. The Endocrinologist indicated he was not aware client #2 had been hospitalized. The Endocrinologist stated "I requested to be notified of hospitalizations. I requested to be notified of blood sugar levels." The Endocrinologist indicated he wanted to be called when client #2's blood sugar levels were over 300. When told it had been changed to 400, the Endocrinologist indicated they should call him when the levels were over 300. The Endocrinologist indicated he had written orders to indicate such. The Endocrinologist indicated he was not aware of any food journals. The Endocrinologist stated "They have not shown me any food journals."

Interview with LPN #2 and administrative staff #1 and #2 on 8/15/13 at 2:30 PM indicated client #2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 210}	Continued From page 62	{W 210}		

saw the endocrinologist on 8/15/13. LPN #2 indicated she took client #2's menu for today 8/15/13 and the client's lunch on hand for 8/15/13. LPN #2 indicated she had client #2's food journal but the doctor did not look at it.

2. A review of client #3's record was conducted at the facility's administrative office on 8/13/13 at 2:30 P.M.. Review of client #3's record indicated a "Nutritional Assessment" dated 6/5/13 which indicated: "Weight: 159 lbs (pounds)...Ideal Body Weight: 169-186...Diet Order: Regular Diet." Review of client #3's "Cumulative Medical" record indicated the following:

Medical notation dated 7/25/13: "...Multiple areas of colon wall thickening, possible mass or colitis. Weight loss continues now at 152.5 pounds, down additional 8 1/2 pounds. Strongly recommend colonoscopy/lower GI testing...Of note came up medicaid ineligible today...Also assess increase calories."

Medical notation dated 7/31/13: "Called [Physician name] spoke to [Nurse name] orders for nutritional supplement...to have weights checked weekly."

Medical notation dated 7/31/13: "Late entry...Appointment to be scheduled for follow-up visit with [Physician name] re: weight loss recommendations for colonoscopy/lower GI testing further evaluations."

Medical notation dated 8/2/13: "[Client #3 Aunt name] called this writer...stated nobody is doing anything about his weight loss...."

Medical notation dated 8/7/13: "Consumer has

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 210}	Continued From page 63	{W 210}		

maintained a weight between 157-159 pounds for the past three months. Consumer consume 100% of all meals and ensure supplement. Weekly weights will continue."

Client #3's 2012 and 2013 Weight Chart indicated the following (not all inclusive):

-May 2012 209 pounds
-June 2012 219 pounds
-July 2012 188 pounds
-August 2012 183 pounds
-September 2012 183 pounds
-October 2012 176 pounds
-November 2012 177 pounds
-December 2012 169 pounds
-January 2013 167 pounds
-February 2013 178 pounds
-March 2013 176 pounds
-April 2013 159 pounds
-May 2013 157 pounds
-June 2013 159 pounds
-July 2013 159 pounds.

Client #3's May 2013 Weight Management risk plan indicated "...[Client #3] had a history of weight loss. [Client #3] was on a portion control diet. [Client #3] is now on a regular diet. Baseline: [Client #3's] current weight is 169. His ideal body weight should be between 165-205." The risk plan indicated "Staff is to encourage [client #3] to eat all his food and encourage him to have seconds. Staff are to monitor [client #3's] food intake by size and report and document his food intake on tracking sheet. Staff should call the Community Services Nurse if [client #3's] food intake is less than 1/4 of the entire meal at every meal." The risk plan indicated the tracking sheets were to be submitted to the Service Coordinator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 210}	Continued From page 64	{W 210}		

every Monday, and the facility's nurse would review the tracking sheets at least monthly. The risk plan indicated client #3 would be weighed once a week at the day program. The risk plan indicated the Health & Safety Tech would monitor the weights and send them into the nurse weekly. The 5/2013 risk plan indicated "...If plus or minus 3lbs (pounds) in a week the Community Services Nurse will evaluate the findings..." and contact the client's doctor. The risk plan indicated the nurse would keep a record of client #3's food consumption.

A review of the Director of Nursing services client weights spread sheet no date noted was conducted on 8/14/13 at 1:30 P.M.. Review of the spreadsheet indicated client #3 was weighed monthly. The spread sheet did not indicate client #3 was weighed weekly.

An interview with the Director of Nursing services (DON) was conducted at the facility's administrative office on 8/14/13 at 2:30 P.M.. When asked how often client #3 was weighed, the DON stated "Monthly." When asked if there was documentation to indicate client #3 was weighed weekly, the DON stated "He is weighed at the day program and when they weigh him they send the information to me and I put the information on my spread sheet." When asked if her documented spread sheet indicated client #3 was weighed weekly, she stated "No, monthly." When asked if client #3's weight loss risk plan had been addressed since his 8.5 pound weight loss noted on 7/25/13, the DON stated "I'm not sure." When asked if the doctor or nutritionist had been contacted after the noted weight loss, the DON stated "I'm not sure."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 210}	Continued From page 65 This deficiency was cited on 7/3/13. The facility failed to implement a systemic plan of correction to prevent recurrence.	{W 210}		
{W 318}	9-3-4(a) 483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Health Care Services for 1 of 2 sampled clients (#2) and for 1 additional client (#3). The facility's Health Care Services failed to ensure its nursing services met the health care needs of the clients it served. The facility's Health Care Services failed to assess, monitor and/or address a client's health care needs in regard to diabetes. The facility's Health Care Services failed to ensure a client's doctor was contacted in regard to the client's elevated/high blood sugar levels, and to obtain clarification in regard to when to contact the physician. The facility's Health Care Services failed to ensure a risk plan was revised and/or developed for client #2. The facility's Health Care Services failed to ensure client #3's weight loss was monitored and/or assessed. Findings include: The facility's Health Care Services failed to ensure its nursing services specifically indicated how client #2 would be monitored at night in	{W 318}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 318}	Continued From page 66 regard to the client's signs/symptoms of low/high blood sugar levels to ensure any change of condition could be immediately addressed. The facility's Health Care Services failed to monitor client #2's low and high blood sugar readings as outlined by the client's physician's order and/or program plan. The facility's Health Care Services failed to ensure the facility's nursing services met the client's health needs in regard to assessing the client timely upon discharge from the hospital and to ensure nursing services carried out physician's orders as written. The facility's Health Care Services failed to ensure the client's physician was notified of a hospitalization and/or notified the physician of high blood sugar level readings. The facility's Health Care Services failed to ensure the dietician was informed/involved in the interdisciplinary team process to assist the facility to review/address the client's elevated sugar levels in regard to the client's diet, and to develop a risk plan for a medical condition. The facility's Health care Services failed to re-assess client #3's weight loss, obtain weekly ordered weights and/or monitor the client #3 in regard to the client's weight loss. Please see W331. This deficiency was cited on 7/3/13. The facility failed to implement a systemic plan of correction to prevent recurrence.	{W 318}		
{W 331}	9-3-6(a) 483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.	{W 331}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 331}	Continued From page 67	{W 331}		

This STANDARD is not met as evidenced by:
Based on observation, interview and record review for 1 of 2 sampled clients (#2) and for 1 additional client (#3), the facility's nursing services failed to meet the nursing needs of a diabetic client and a client who had lost significant amount of weight.

Findings include:

1. The facility's reportable incident reports, Incident/Accident Reports (IAR) and/or investigations were reviewed on 8/12/13 at 3:23 M. The facility's reportable incident reports, IARs and/or investigations indicated the following:

-7/10/13 "This Service Coordinator (SC) (SC #1) received a phone call from the group home at approximately 8:30 AM on 7/10/13 stated that consumer [client #2] appeared lethargic and his gait was unsteady (sic). Staff were directed to check his blood glucose level. It was 210. The nurse directed staff to transport [client #2] to [name of hospital] in [name of city], In. Blood tests and CT scan yielded no significant findings. [Client #2] was not admitted to the hospital, he was discharged from the ER (emergency room) at 12:30 PM on 7/10/13. No new medications, prescriptions for a walker provided by the ER physician.

At 1:00 PM Residential staff transported consumer [client #2] from the hospital to the group home after ER discharge. Upon disembarking the vehicle (at group home) [client #2's] body shook uncontrollably. Staff assisted [client #2] to the ground, no injury noted. 911 called...[Client #2] was transported back to the ER via ambulance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 331}	Continued From page 68	{W 331}		

At 2:00 PM, the ER physician noted low Depakote (seizure) levels from previous work (taken at initial visit). Consumer [client #2] was given Zalerate 100ml (milliliters) intravenously while in the ER to bring his depakote levels up. [Client #2] was discharged from the ER at 5:00 PM on 7/10/13. No new medications, prescription for a walker written. The ER physician recommended that [client #2] follow-up with his primary care physician (PCP) and that [client #2] continue to take his current medications as prescribed."

The facility's 7/19/13 follow-up report indicated client #2 saw his PCP. The follow-up report indicated client #2's "...increasing unsteadiness and uncoordinated movements are correlated with his diagnosis of Parkinson's Disease (disorder of the brain that lead leads to tremors and difficulty walking). It is recommended he follow-up with a neurologist...." The follow-up report also indicated client #2 would see a physical therapist (PT) and occupational therapist (OT) for the need/use of adaptive equipment.

-7/11/13 "[Client #2] came into the workshop at 9:00 AM with signs of hyperglycemia (high blood sugar) which included shakiness and combativeness. Health & (and) Safety (H&S) tech tested [client #2's] sugar level which was 369. [Client #2] was given water and H&S Tech contacted Residential Nurse and left message with Director of Health Services. [Client #2] was closely monitored by staff and H&S Tech for any changes. [Client #2's] level was checked again and tested at 463. Facility Director called 911 and EMT (emergency medical technician) arrived and checked [client #2's] levels which tested at 476. [Client #2] was then transported to [name of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 331}	Continued From page 69	{W 331}		

hospital]."

The facility's 7/17/13 follow-up report indicated client #2 followed up with his Endocrinologist (diabetes specialist) on 7/15/13 and the doctor changed the client's insulin dosage.

-7/26/13 "Consumer [client #2] was non-responsive during a routine bed check. Staff checked [client #2's] glucose and it was in the 40's, and the Nurse was notified. 911 was called and [client #2] was transported to [name of hospital]."

-7/31/13 "[Client #2] was at [name of hospital] in [name of city], Indiana for a scheduled EEG on 7/31/13. During the procedure [client #2] began to show signs of hypoglycemia (low blood sugar). His sugar dropped below 30. [Client #2] was rushed to [name of hospital] emergency room. His blood sugar was stabilized and he was admitted to the hospital for further observation."

The facility's 7/31/13 IAR indicated client #2 would not respond to staff when they called his name. The IAR indicated the client was taken to the ER where it was determined his blood sugar level was below 30 and he was admitted to the hospital.

-8/5/13 "Director of Health Services (DHS) reviewed hospital discharge orders for [client #2], which instructed that his blood sugar levels were to be checked prior to lunch to determine if insulin coverage was needed. The nurse failed to follow up and train day program staff on the new doctor orders which resulted in [client #2] not having his blood sugar checked appropriately on 8/5/13 and 8/6/13. The nurse immediately went to the East

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 331}	Continued From page 70	{W 331}		

center (facility owned day program) to provide Novolog insulin, ensured that the glucometer and test strips were available, transcribed the orders on the MAR (medication administration record), and trained the health and safety tech on the new orders. The Director of Health Services will follow up with [client #2's] primary care physician."

The facility's 8/9/13 follow-up report indicated "...3. What measures are being implemented to prevent this from happening again? Training was done with the nurses which consisted of thorough review of all discharge hospital orders and ensure all orders are carried out."

The facility's 8/5/13 IAR indicated LPN #1 was the nurse involved in the error.

The facility's training records were reviewed on 8/12/13 at 4:00 PM. The facility's 8/5/13 Individual Client Training Forms indicated the DHS completed training procedures for discharge, reviewing discharge orders, clarifying orders and following up with treatment and medication changes with LPN #1 and LPN #2 of the group homes.

Interview with administrative staff #2 on 8/12/13 at 4:15 PM indicated the DHS retrained 2 of 4 group home nurses. Administrative staff #2 indicated the DHS only trained the nurses who worked with the Fourteenth Lane group home. Administrative staff #2 stated LPN #1 and LPN #2 were not the only nurses who worked on call as LPN #1 was a "temporary" (part time) nurse and LPN #2 was a full time nurse. The facility's nursing services failed to train all nurses in regard to discharge orders to ensure continuity of care with clients.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 331}	Continued From page 71	{W 331}		

During the 8/12/13 observation period between 5:15 PM and 7:10 PM, at the group home, client #2 did not wear a gait belt and/or utilize a walker. Staff #1 and #2 did not implement any desensitization training with client #2.

Client #2's record was reviewed on 8/12/13 at 5:22 PM and on 8/13/13 at 1:10 PM. Client #2's 7/10/13 hospital records indicated client #2 was seen in the ER on 7/10/13. The 7/10/13 ER note indicated client #2's diagnoses included, but were not limited to, "Uncoordinated movements, Parkinson Disease, and Type II diabetes mellitus without control." The ER note indicated client #2 was to follow-up with his PCP in 2 days and a "roller walker" was ordered for client #2. Client #2's 7/10/13 lab report indicated client #2's glucose level was 280 at the ER and the client's Valproic Acid level was "22.5 (L)." Client #2's second 7/10/13 ER note indicated client #2's diagnosis included, but was not limited to, Convulsions." The second 7/10/13 note indicated client #2's seizures were "Non-Epileptic Seizures." The attached 7/10/13 Discharge Instructions indicated "Non-epileptic seizure (NES) is a short period of symptoms that change how you move, think, or feel. NES looks like an epileptic seizure, but there are no electrical changes in the brain. NES is a serious condition. Early diagnosis and treatment are needed to prevent further problems...."

Client #2's 7/31/13 History and Physical (H&P) indicated client #2 was seen in the ER for the chief complaint of Hypoglycemia. The H&P indicated "...patient was reportedly developing diaphoresis (excessive sweating commonly associated with shock and other medical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 331}	Continued From page 72	{W 331}		

emergency conditions) and restless while having EEG done today; patient was noted to have low blood sugar. Hypoglycemia has been recurrent past few days; had 3 ER visits at local ER...." The 7/31/13 H&P indicated client #2 had "renal insufficiency, most likely from medication effect....Will consult [name of doctor] nephrology...."

An 8/2/13 After Visit Summary indicated client #2 was discharged back to the group home on 8/2/13. The summary indicated client #2 was to follow up with his PCP in 1 week and the nephrologist in 5 weeks with labs to be done in 4 weeks. The 8/2/13 summary indicated client #2 was placed on a sliding scale. The 8/2/13 summary indicated "Other Prescriptions... Novolog Mix 70/30 Flex pen inject 5 units into the skin 2 (two) times daily before meals" and "insulin apart (sliding scale insulin coverage) Novolog Flex Pen inject three times daily with meals BS (blood sugar) 150-199 1U (unit) SQ (subcutaneous)
200-249-2U SQ
250-300-3U SQ
301-349-4U SQ
350-400-5U SQ
> (more than) 400-6 units SQ call MD (medical doctor)." The 8/2/13 Patient Instructions indicated the facility was to monitor client #2's glucose levels 4 times daily at meals and at bedtime (HS). The 8/2/13 After Visit Summary indicated a doctor at the hospital made the medication changes, not client #2's PCP and/or endocrinologist.

Client #2's 8/6/13 Nephrology report indicated client #2's diagnosis included, but was not to limited to, "Chronic kidney disease, stage 3"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 331}	Continued From page 73	{W 331}		

(moderately reduced kidney function).

Client #2's Cumulative Medical Records and physician orders indicated the following (not all inclusive):

-7/10/13 "Sent to E.R. for eval (evaluation) & tx (treatment) d/t (due to) staff reporting (change) in medical condition (unsteady gait)."

-7/10/13 "Eval @ (at) [name of hospital] DX: uncoordinated movements, Parkinson Disease, Type II DM (diabetes mellitus), convulsions. Labs & CT head done. Rx (prescription) for walker. Appt (appointment) (with) [name of doctor] (neurologist) 7-23-13 @ 10 AM, Appt OT/PT eval - 7-19-13 @ 9 AM."

-7/11/13 "Gait belt DX (diagnosis): unsteady gait."

-7/15/13 (8:25 AM) "Blood Sugar (increase) 419. Status update given to [name of endocrinologist] office- Client taken to Dr's (doctor's) office- orders rec'd (received) to (increase)- a.m. insulin dose to 20 units and p.m. dose to 10 units and return to office in 4 weeks- appt scheduled 8-15-13 @ 10:30 AM."

-7/22/13 "Rec'd phone call from staff on 7-20-13 @ 7:15 pm- reports client BS 21 glucagen subcut (subcutaneous) given - unable to wake client up- breathing/snoring loud; sweating profusely- informed to call 911 immediately. EMS admin. IV Dextrose as per staff BS (increased) to 100 - client aroused- no ER transport needed - informed to give dinner, hold P.M. insulin dose @ this time; monitor condition; repeat BS @ 10 PM & call on-call nurse (with) results. At 10 PM- blood sugar 265- Continue to monitor client

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 331}	Continued From page 74	{W 331}		

throughout night."

-7/23/13 "...New Neuro pt (patient) sent here at the request of the DON (Director of Nursing) at The Arc. Pt has been diagnosed with Parkinson Disease. Pt was recently seen in the ER at [name of hospital] for full body tremors per the social worker here with him today. Pt is on Depakote but he doesn't have a diagnoses (sic) of seizures." The 7/23/13 note indicated Carbidopa-Levodopa (Parkinson Disease) 25-100 milligrams daily with meals. The note indicated the facility was to start with breakfast for 1 week, then 1 with breakfast and lunch for 1 week, then 1 with each meal. The neurology report indicated the Neurologist ordered an EEG awake and asleep for client #2. The report also indicated client #2 was to return in 6 weeks or as needed. The 7/23/13 report indicated client #2 was given a diagnosis of Seizure.

-7/23/13 "Spoke w/ (with) [name of endocrinologist] re: (referring to) elevated blood sugars over 300 and no return phone calls when Dr. paged; orders rec'd to continue to call [name of endocrinologist] for BS > 300 via pager or cell phone; insulin increased to 25 units @ bkfst (breakfast) and 20 units (with) dinner & F/U (follow-up) for appt next wk (week) (call for appt)."

-7/23/13 Faxed note indicated "1.) Continue to call [name of endocrinologist] for blood sugars > 300. His cell number is [number listed] or pager [number listed]. 2. Increased Novelin 70/30 to 25 units before breakfast & 20 units before dinner. Please make sure patient eats when you give insulin." On the bottom of the attached order sheet, the facility's nurse sought clarification in regard to the medication as it was to be Novolog

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 331}	Continued From page 75	{W 331}		

25 before breakfast and 20 units at supper.

-7/23/13 (5:30 PM) "While visiting home (this writer) (Director of Health Services)- client's BS 45 informed to hold p.m. insulin- 1 cup milk, slice of bread & serving of rice given prior to leaving home for outing. Staff informed to obtain BS during outing (with) any s/s (signs and symptoms) of hypo/hyperglycemia & repeat BS when return to home."

-7/23/13 (8:20 PM) "Client (without) incident @ outing. B.S. 53 when returned home- sub Q (subcutaneous) glucagen given per staff; ate supper @ outing around 7-7:15 pm- informed to repeat BS in 1 hour- call w/results. 9:25 PM BS up to 98 informed to give HS snack graham crackers & cup of milk."

-undated note "In case of emergency go to the emergency room of the hospital closest to you and have [name of endocrinologist] paged [pager number listed] wait for two beeps then place in your number with a touch tone phone. Then wait two beeps again. Then hang up. [Name of endocrinologist] will return your call. [Name of Endocrinologist] wants to also be notified about B/S over 300...Low BS- Milk or juice."

-7/26/13 "Rec'd phone call from staff @ 5:40 a.m. S 47- client sweating profusely; c/o (complaints of) stiff muscles - informed to call 911- adm (administer) sub Q glucagen. This writer (DHS) arrived @ home approx (approximately) 6:15 a.m. - EMS present - BS 42 per EMS; IV dextrose given- [client #2] cont. (continue) to sweat profusely/EMS attempting to arouse - repeat BS per EMS after IV dextrose (decreased) 30's - taken to E.R. for evaluation."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 331}	Continued From page 76	{W 331}		

-7/26/13 Novolog 70/30 ordered 15 units with breakfast and 10 units with dinner.

-7/31/13 Client #2 went to hospital for EEG testing and showed signs of hypoglycemia. The note indicated client #2 was transported to the ER and admitted with a blood sugar below 30. The note indicated client #2 was to have a kidney ultrasound and blood work completed.

-8/5/13 "Assessed client post hosp (hospital) return. Client alert et (and) non verbally responsive. 0 (zero) signs of distress noted resp (respirations) even & unlabored bilat (bilateral) lung sounds clear, bowels active x 4 quads, skin W/D intact. V/S (vital signs) stable, new orders received et noted. Client to follow up (with) [name of PCP] in 1 wk et [name of Neurologist] in 5 wks." The facility's nursing services failed to assess client #2 upon discharge from the hospital on 8/2/13 and/or ensure the new orders were implemented.

-8/12/13 Client #2 saw his family doctor for a follow-up to the 7/31/13 hospitalization.

Client #2's 7/19/13 PT and OT evaluation indicated client #2 was a fall risk and should exercise safety around sharp objects or moving objects. The assessment indicated client #2 was "...unable to follow 1 step commands consistantly (sic)...." The PT assessment indicated "Current Home Program: pt is unable to follow any exercises. No HEP (home exercise program) provided/Pt inappropriate...Recommendation/Plan OT Plan **Requires OT follow Up**: No PT is not appropriate for OT services at this time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 331}	Continued From page 77	{W 331}		

Recommend 24 hour supervision in structured environment. This patient will be seen for skilled occupational therapy for optimal return to independence with meaningful occupations...."

Client #2's 8/5/13 Medication Change Form indicated client #2 had a new medication order/change. The 8/5/13 form indicated "Give Novolog 70/30 5 units 2xs (times) a day before breakfast and dinner subq. Give Insulin apart Novolog 3xs a day with meals subq if BS reading is
150-199 give 1unit
200-249 give 2units
250-300 give 3units
301-349 give 4 units
350-400 give 5 units
If BS is greater than 400 give 6units (sic) and call Nurse/MD...."

The 8/5/13 change form and/or Cumulative Medical Record indicated the facility neglected to obtain clarification in regard to when the doctor and/or endocrinologist wanted to be notified as the 7/23/13 order indicated at 300 and the 8/5/13 order indicated 400.

Client #2's August 2013 Medication Administration Record (MARs) indicated the facility monitored client #2's blood sugar levels in the morning, lunch, PM (evening before dinner) and at bed time. Client #2's 8/13 MAR indicated the following blood sugar levels (not all inclusive):

-8/2/13 bed time 328
-8/3/13 lunch 444
-8/3/13 bed time 312
-8/4/13 lunch 352
-8/4/13 bed time 341

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 331}	Continued From page 78 -8/5/13 morning 304 -8/5/13 evening/dinner 342 -8/6/13 evening/dinner 310 -8/8/13 evening/dinner 321 -8/10/13 lunch 334 -8/10/13 evening/dinner 435 -8/10/13 bed time 371 -8/11/13 lunch 344 -8/11/13 evening/dinner 439 -8/11/13 bed time 352. The facility's Residential Services Pager Review was reviewed on 8/13/13 at 1:40 PM. The facility's pager records indicated the following in regards to client #2's blood sugar levels/readings: -7/8/13 302 at 5:55 PM, client #2 was "unsteady and shaking." -7/18/13 352 at 8:07 AM -7/18/13 353 at 6:12 PM, and then 379 with a different glucometer. -7/22/13 408 at 5:53 PM -7/24/13 330 at 9:18 PM -7/27/13 487 at 6:30 PM "Give p.m. insulin dose feed dinner. Call back w/results in 2-21/2 hours after eating. 10 pm BS going down 337." -7/28/13 398 at 6:20 PM "Informed to give p.m. insulin dinner re(check) in 2/1/2-3 hrs (hours). Call w/results." -8/2/13 328 at 10:31 PM -8/3/13 456 at 10:41 AM -8/3/13 444 at 1:39 PM -8/4/13 341 (no time documented) -8/5/13 304 at 6:50 AM. Client #2's pager log and/or Cumulative Medical Record indicated the facility's nurses failed to call/inform the doctor/endocrinologist of client #2's high blood sugar readings over 300 prior to	{W 331}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 331}	Continued From page 79	{W 331}		

8/5/13 and/or over 400 after 8/5/13.

Client #2's undated typed sheet indicated client #2 was to carry a sack lunch and a snack to the day program daily, document what was sent and what the client ate.

Client #2's 8/2013 food journal book indicated client #2 received an 1800 calorie ADA (diabetic) diet. Client #2's 8/2013 menus indicated "Hot lunch Eat at workshop" on 8/8/13, 8/9/13, 8/12/13, 8/15/13, 8/16/13, 8/19/13, 8/22/13, 8/23/13, 8/26/13, 8/29/13 and 8/30/13.

Client #2's 8/2013 food journal book indicated the following menu/food items sent for the client's lunch on the following days:

-8/8/13 Three ounces of chicken, 1/2 cup macaroni and cheese, 1/2 cup potatoes, 1 slice of bread, orange slices and water.

-8/9/13 Three ounces of meat, 1/2 cup of noodles, garlic bread, 1/2 cup of peas and carrots, 1 cup mandarin oranges, water and 8 ounce cup of milk.

-8/11/13 Three ounces of polish sausage, 1/2 cup dirty rice, 1/2 bun, salad, fruit cup, yogurt and water.

-8/12/13 2 sliced hot dogs, 1 slice of bread, 1 serving of rice, 1 serving of salad, fruit cup, graham crackers and 16 ounces of water.

Client #2's 1800 calorie ADA diet indicated the facility's nursing services failed to to have the dietician review, develop and/or approve the above mentioned sack lunch menus for client #2.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 331}	Continued From page 80	{W 331}		

Client #2's 8/13 menu indicated the facility's nursing services failed to ensure an approved menu was developed for client #2's sack lunch menu for the upcoming days of 8/15/13, 8/16/13, 8/19/13, 8/22/13, 8/23/13, 8/26/13, 8/29/13 and 8/30/13.

Client #2's 6/5/13 Annual Nutritional Assessment indicated "...Client on Diabetic 1800 calorie meal plan as ordered by MD. Staff monitor carbohydrate counting at mealtime. Continue to monitor blood sugar." The facility's nursing services failed to ensure the dietician reviewed and approved all lunch menus developed by the group home staff. The facility's nursing services failed to have client #2's 1800 calorie ADA diet re-assessed in regard to the client's high/low blood sugar levels to ensure the menus did not contain a lot of starches, carbohydrates and/or natural sugars which could affect client #2's blood sugar levels.

Client #2's 8/7/13 Diabetic (risk) Plan indicated "Menus are developed and sent to the Nutritionist for review for approval and revisions." The 8/7/13 risk plan indicated client #2 was to carry a sack lunch daily. The 8/7/13 risk plan indicated "...During sleep check for crying out or thrashing in bed as he may be having nightmares. He may sweat through his clothing. If noted check his blood sugar. If blood sugar is above 400 check for the following symptoms (Hyperglycemia)
-Frequent urination
-Fatigue
-Abdominal Pain
-Dry Mouth
-Increased thirst
-Headache
-Nausea and Vomiting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 331}	Continued From page 81 -Weakness -blurred (sic) vision -Fruity smelling breath -Shortness of Breath -Confusion If blood sugar is above 150 Novolog flexpen 100units/ml injection will be administered per sliding scale MD orders, (sic) If [client #2's] blood sugar is above 400 6units (sic) of Novolog flexpen should be administered Sub-Q per sliding scale MD orders and Call the nurse/nurse to notify MD...If 911 is called an Incident report should be completed....." Client #2's 8/7/13 risk plan failed to specifically indicate how often facility staff were to monitor client #2 at night in regard to the client's signs/symptoms of low/high blood sugar levels to ensure any change of condition could be immediately addressed. Client #2's 7/2013 risk plan for Parkinson's Syndrome indicated "Staff will to monitor [client #2] while ambulating (sic)...Staff will make sure that [client #2] and the bathroom floor are fully dried after showering/bathing...Staff will make sure walkways are clear of obstacles and tripping hazards...[Client #2] has been prescribed a gait belt and walker. However, at this time he is combative in using the gate (sic) belt and the walker. A desensitization plan has been developed please see this plan...." Client #2's 7/2013 risk plan indicated the facility's nursing services failed to specifically indicate when staff should attempt to use the gait belt, and/or indicate how the facility staff were to keep the client safe when the client's gait was unsteady. Client #2's record and/or 2/28/13 Individual Program Plan (IPP) indicated the facility's nursing services failed to address/develop a risk plan for the client's Chronic Kidney Disease.	{W 331}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 331}	Continued From page 82	{W 331}		

Client #2's 7/13 behavior plan indicated "A gait belt and walker has (sic) been recommended for [client #2] to reduce these falls. He is extremely resistant to these items. A desensitization plan for this is being added to his plan. [Client #2] is also resistant to some medical appointment desensitization for appointment is also be in added (sic). Client #2's 7/13 behavior plan indicated the desensitization plans for the gait belt and the walker were to be run/implemented 5 times a day at the group home and at the day program.

Client #2's 2/28/13 IPP indicated client #2's interdisciplinary team (IDT) met on 7/10/13, 7/11/13 and on 7/19/13. Client #2's above mentioned IDT notes and/or the client's 2/28/13 IPP indicated the IDT failed to meet since client #2 was discharged from the hospital on 8/2/13 to review and/or make needed changes to the client's risk plans. Client #2's 2/28/13 IPP and/or record indicated the facility's nursing services contacted the dietician to ensure the dietician gave input and/or was included in the IDT meetings. Client #2's IPP and/or record indicated the facility's nursing services failed to review and/or ensure the client's physician's reviewed the client #2's 1800 calorie ADA diet menus/food journals in regard to the client's high/low blood sugar readings/levels to determine if there was any correlation.

Interview with staff #1, #2 and SC #1 on 8/12/13 at 6:41 PM when asked when client #2 would be transported to the hospital, staff #1 and SC #1 stated client #2 would be transported to the hospital when the client was "unresponsive." SC #1 stated client #2's doctor would be called if it

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 331}	Continued From page 83	{W 331}		

was "significant-irregularities." When asked how client #2 was monitored at night in regard to his blood sugar/symptoms, staff #1 stated "I check him every hour when I work." Staff #2 indicated she did not work midnights.

Interview with the dietician on 8/13/13 at 1:44 PM, by phone, indicated she last assessed client #2 in the month of May 2013. When asked if the facility had contacted her in regard to the client's elevated and low blood sugar levels and his diet, the dietician stated "No." The dietician indicated she was not aware client #2 had been hospitalized until she came to the facility to do an inservice training. When asked if she was aware client #2 was diagnosed with Chronic Kidney Disease stage 3, the dietician stated "No." The dietician indicated she was not aware of any insulin changes from the 7/31/13 hospitalization. The dietician stated she would "Definitely want to be notified in regard to low blood sugar or change in medication, diet changes to go back and re-evaluate client." The dietician stated she should be made aware of any "abnormal readings" which were high or low. The dietician stated she did not attend the IDT meetings but had discussed the client's "Plan of Care" in the past. The dietician indicated she had not communicated with the Endocrinologist in regard to the client's menus. The dietician indicated she reviewed and approved the client's menus that were sent to her. The dietician indicated the facility had not asked her to re-assess client #2.

Interview with administrative staff #2, SC #1 and #2, and the DHS on 8/14/13 at 1:50 PM indicated client #2 was hospitalized on 7/31/13 for low blood sugar level reading when the client was at the hospital for an EEG. The DHS indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 331}	Continued From page 84	{W 331}		

client #2 was discharged on 8/2/13 and placed on a sliding scale. The DHS could not locate the order for the changes of the insulin and/or doctor notification. The DHS stated client #2's blood sugar levels were "up and down." The DHS indicated the dietician was aware of client #2's low and high blood sugar level readings. The DHS indicated client #2 started carrying sack lunches July 28, 2013 versus purchasing hot meals at the workshops. The DHS and SC #1 indicated they had not reviewed the menus to ensure all lunches had been reviewed and/or approved by the dietician. SC #1 indicated the 8/2013 menu was approved by the dietician when client #2 was still eating at the workshop. SC #1 indicated no one had resubmitted menus for the days the menu called for eating at the workshop. The DHS and DS #1 indicated no one reviewed the menus since the dietician approved them. The DHS, SC #1 and administrative staff #2 indicated the dietician had not attended any IDT meetings. SC #1 stated "No one thought of inviting the dietician to the program (meetings)." SC #1 and #2 indicated there had been no additional IDTs since 7/19/13. The DHS indicated she was not aware client #2 had a diagnosis of Chronic Kidney Disease stage 3. The DHS indicated diabetes could affect the kidneys function. SC #1 and the DHS indicated client #2 did not have a risk plan for his new diagnosis. SC #1 and #2 indicated client #2 did not want to wear his gait belt and/or use a walker. SC #2 indicated client #2 had a desensitization plan for using his walker and gait belt. SC #2 indicated he had trained the day program staff in regard to the desensitization plan, but he had not trained the group home staff in regard to the behavior plan. The DHS indicated client #2 had a diagnosis of Parkinson Disease. The DHS indicated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 331}	Continued From page 85	{W 331}		

neurologist and evaluation by the OT and PT indicated client #2 would not be a good candidate for a walker but a gait belt had been put into place. When asked how the facility was keeping client #2 safe as the client did not want to utilize a gait belt, SC #1, the DHS and administrative staff #2 indicated the IDT would need to put something in place. The DHS indicated client #2's Endocrinologist was made aware of client #2's low and high blood sugars. The DHS indicated the doctor would not always return his pages/calls. The DHS indicated she spoke with the doctor on 7/23/13 and nursing staff was to call his office, the pager and/or his cell phone. The DHS indicated the doctor still wanted to be notified if client #2's blood sugar levels were over 300. The DHS indicated she was not aware the 8/2/13 discharge orders had changed the notification to 400. The DHS indicated the facility's nurse should have sought clarification of the order to notify the clients' doctors of blood sugar levels over 300 or 400. When asked if the facility's nurse notified the doctor of client #2's following high blood sugar levels, the DHS stated "no (to each one)" as there was no documentation the doctor was called:
-7/8/13 302 at 5:55 PM
-7/18/13 352 at 8:07 AM
-7/18/13 353 at 6:12 PM, and then 379 with a different glucometer.
-7/22/13 408 at 5:53 PM
-7/24/13 330 at 9:18 PM
-7/27/13 487 at 6:30 PM
-7/28/13 398 at 6:20 PM
-8/2/13 bed time 328
-8/3/13 lunch 444
-8/3/13 bed time 312
-8/4/13 lunch 352
-8/4/13 bed time 341

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 331}	Continued From page 86 -8/5/13 morning 304 -8/5/13 evening/dinner 342 -8/6/13 evening/dinner 310 -8/8/13 evening/dinner 321 -8/10/13 lunch 334 -8/10/13 evening/dinner 435 -8/10/13 bed time 371 -8/11/13 lunch 344 -8/11/13 evening/dinner 439 -8/11/13 bed time 352. The DHS indicated the doctor should have been called in regard to blood sugar levels over 300. The DHS, SC #1 and SC #2 indicated client #2's IPP did not specifically indicate how facility staff were to monitor the client at night in regard to signs and symptoms of high and/or low blood sugars. The DHS and SC #1 indicated the IDT had not re-assessed client #2's diet/food journal/consumption in regard to the client's low and/or high blood sugar levels. Interview with the Endocrinologist on 8/15/13 at 1:45 PM, by phone, indicated client #2 was a patient he followed. The Endocrinologist indicated he saw client #2 at his office on 8/15/13. The doctor indicated client #2's blood sugar level over 400 in his office. The Endocrinologist indicated when he asked the nurse what client #2's morning blood sugar reading was, the Endocrinologist indicated the nurse could not tell him. The Endocrinologist stated he had written orders for client #2's blood sugar levels to be monitored, but the facility did not bring all the readings with them except the "PM readings." The doctor indicated he made some changes in regard to the client's insulin on 8/15/13. The Endocrinologist indicated the nurse told him the client's PCP was also seeing the client for his diabetes. The doctor stated he told them the	{W 331}		

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{W 331}	Continued From page 87	{W 331}		

PCP could follow his diabetes and if his PCP "could not handle" they could bring the client back to him. When asked if he was aware of client #2's hospitalization, the Endocrinologist asked when client #2 was hospitalized and why. The Endocrinologist indicated he was not aware client #2 had been hospitalized. The Endocrinologist stated "I requested to be notified of hospitalizations. I requested to be notified of blood sugar levels." The Endocrinologist indicated he wanted to be called when client #2's blood sugar levels were over 300. When told it had been changed to 400, the Endocrinologist indicated they should call him when the levels were over 300. The Endocrinologist indicated he had written orders to indicate such. The Endocrinologist indicated he was not aware of any food journals. The Endocrinologist stated "They have not shown me any food journals." The Endocrinologist indicated he was concerned the facility was not monitoring client #2's blood sugar levels as ordered.

Interview with LPN #2 and administrative staff #1 and #2 on 8/15/13 at 2:30 PM indicated client #2 saw the endocrinologist on 8/15/13. Administrative staff #1 indicated LPN #2 did not know she was to take client #2 to the doctor's appointment as the DHS was to take the client but the DHS had resigned the morning of 8/15/13. LPN #2 indicated client #2's blood sugar level was 432 at the doctor's office and the client was given 15 units of Novolog 70/30 at the doctor's office. When asked what documents were taken to the appointment, administrative staff #1 indicated LPN #2 was not able to take the blood sugar levels as they were not available. LPN #2 indicatedshe took the lunch time blood sugar level readings only. LPN #2 indicated she did not

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	15G245	A. BUILDING _____ B. WING _____	R 08/16/2013

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{W 331}	Continued From page 88	{W 331}		

take the AM readings, PM and bed time readings for the doctor to review. LPN #2 indicated she took client #2's menu for today 8/15/13 and the client's lunch on hand for 8/15/13. LPN #2 indicated she had client #2's food journal but the doctor did not look at it. When asked if the endocrinologist had been made aware of the client's hospitalization, administrative staff #1 indicated the doctor was told of the hospitalization. LPN #2 indicated the hospital was told to call the endocrinologist upon admission. LPN #2 indicated the hospital did not call him. LPN #2 stated client #2's doctor "removed" the sliding scale and placed client #2 on 25 units Novolog at breakfast and 20 units at supper. LPN #2 indicated nursing staff were to assess clients within 24 hours of discharge from the hospital. Administrative staff #1 indicated the previous nurse did not do a timely assessment of client #2. Administrative staff #2 stated "An investigation was done to determine if an investigation was to be done. They said no. When came to me I told them this should be investigated as neglect."

Interview with administrative staff #1 on 8/16/13 at 10:50 AM indicated nursing staff would send the medication/order change form to the group home when clients' medications were changed. Administrative staff #1 indicated nursing staff had 24 hours to assess a client once discharged from the group home per the facility's policy. Administrative staff #1 indicated an investigation was conducted in regard to the 8/5/13 allegation of neglect in regard to client #2's discharge from the hospital/physician's orders. Administrative staff #1 indicated the group home checked client #2's blood sugar at the lunch meal and administer insulin per the sliding scale if needed on 8/3, 8/4,

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{W 331}	Continued From page 89 8/5 and 8/6/13. Administrative staff #1 indicated the group home staff had called the on-call nurse as the orders sent home with the client were different from what the client had received prior to the hospitalization. Administrative staff #1 stated the on-call nurse "walked them through writing the orders on the MAR." Administrative staff #1 stated LPN #1 indicated on 8/2/13, "She (LPN #1) was not going to the group home at 4:00 PM." Administrative staff #1 indicated LPN #1 was no longer employed with the facility. 2. A review of client #3's record was conducted at the facility's administrative office on 8/13/13 at 2:30 P.M.. Review of client #3's record indicated a "Nutritional Assessment" dated 6/5/13 which indicated: "Weight: 159 lbs (pounds)...Ideal Body Weight: 169-186...Diet Order: Regular Diet." Review of client #3's "Cumulative Medical" record indicated the following: Medical notation dated 7/25/13: "...Multiple areas of colon wall thickening, possible mass or colitis. Weight loss continues now at 152.5 pounds, down additional 8 1/2 pounds. Strongly recommend colonoscopy/lower GI testing...Of note came up medicaid ineligible today...Also assess increase calories." Medical notation dated 7/31/13: "Called [Physician name] spoke to [Nurse name] orders for nutritional supplement...to have weights checked weekly." Medical notation dated 7/31/13: "Late entry...Appointment to be scheduled for follow-up visit with [Physician name] re: weight loss recommendations for colonoscopy/lower GI testing further evaluations."	{W 331}		

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{W 331}	Continued From page 90	{W 331}		

Medical notation dated 8/2/13: "[Client #3 Aunt name] called this writer...stated nobody is doing anything about his weight loss...."

Medical notation dated 8/7/13: "Consumer has maintained a weight between 157-159 pounds for the past three months. Consumer consume 100% of all meals and ensure supplement. Weekly weights will continue."

Client #3's 2012 and 2013 Weight Chart indicated the following (not all inclusive):

-May 2012 209 pounds
-June 2012 219 pounds
-July 2012 188 pounds
-August 2012 183 pounds
-September 2012 183 pounds
-October 2012 176 pounds
-November 2012 177 pounds
-December 2012 169 pounds
-January 2013 167 pounds
-February 2013 178 pounds
-March 2013 176 pounds
-April 2013 159 pounds
-May 2013 157 pounds
-June 2013 159 pounds
-July 2013 159 pounds.

Client #3's May 2013 Weight Management risk plan indicated "...[Client #3] had a history of weight loss. [Client #3] was on a portion control diet. [Client #3] is now on a regular diet. Baseline: [Client #3's] current weight is 169. His ideal body weight should be between 165-205." The risk plan indicated "Staff is to encourage [client #3] to eat all his food and encourage him to have seconds. Staff are to monitor [client #3's]

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{W 331}	Continued From page 91	{W 331}		

food intake by size and report and document his food intake on tracking sheet. Staff should call the Community Services Nurse if [client #3's] food intake is less than 1/4 of the entire meal at every meal." The risk plan indicated the tracking sheets were to be submitted to the Service Coordinator every Monday, and the facility's nurse would review the tracking sheets at least monthly. The risk plan indicated client #3 would be weighed once a week at the day program. The risk plan indicated the Health & Safety Tech would monitor the weights and send them into the nurse weekly. The 5/2013 risk plan indicated "...If plus or minus 3lbs (pounds) in a week the Community Services Nurse will evaluate the findings..." and contact the client's doctor. The risk plan indicated the nurse would keep a record of client #3's food consumption.

A review of the Director of Nursing services client weights spread sheet no date noted was conducted on 8/14/13 at 1:30 P.M.. Review of the spreadsheet indicated client #3 was weighed monthly. The spread sheet did not indicate client #3 was weighed weekly.

An interview with the Director of Nursing services (DON) was conducted at the facility's administrative office on 8/14/13 at 2:30 P.M.. When asked how often client #3 was weighed, the DON stated "Monthly." When asked if there was documentation to indicate client #3 was weighed weekly, the DON stated "He is weighed at the day program and when they weigh him they send the information to me and I put the information on my spread sheet." When asked if her documented spread sheet indicated client #3 was weighed weekly, she stated "No, monthly." When asked if client #3's weight loss risk plan

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{W 331}	Continued From page 92 had been addressed since his 8.5 pound weight loss noted on 7/25/13, the DON stated "I'm not sure." When asked if the doctor or nutritionist had been contacted after the noted weight loss, the DON stated "I'm not sure." This deficiency was cited on 7/3/13. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-6(a)	{W 331}		